

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death

retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7931787												
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 12/14/79									2b. HOUR 5:30 PM												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS										
Ralph J. Alderton						May 6, 1923			56 yrs.			MONTHS DAYS		HOURS MIN										
3. SEX			4. RACE			7. DATE OF BIRTH			8. AGE (IN YEARS LAST BIRTHDAY)			9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
MALE			WHITE			MONTH DAY YEAR			56 yrs.			WASHINGTON COUNTY MD.		HAGERSTOWN		WASHINGTON COUNTY Hospital			Mechanic			Auto		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
HAGERSTOWN			WASHINGTON COUNTY Hospital			Mechanic			Auto															
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS												
W. Va.			Morgan			Paw Paw			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Woodrow Section												
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																					
FIRST MIDDLE LAST			FIRST MIDDLE LAST																					
Charles P. Alderton			Nellie Haymaker																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS															
No			234-54-9775			Mrs Ralph Alderton, c/o Postmaster			Paw Paw, W. Va. 25434															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
IMMEDIATE CAUSE (a) 4241 CARDIOPULMONARY ARREST																								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																								
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE																								
DUE TO, OR AS A CONSEQUENCE OF (c) PULM. STENOSIS / CONVONARY DISEASE																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from 12/13/75 to 12/14/75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																								
22b. SIGNATURE W. Wooster			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/14/1979															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Wooster			22e. ADDRESS 1825 Howell Rd Hagerst, MD																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/18/1979			23c. NAME OF CEMETERY OR CREMATORIAL Woodrow Cem., Berkeley Spgs			23d. LOCATION CITY OR TOWN Paw Paw, (Morgan) W. Va.			COUNTY STATE												
24. FUNERAL DIRECTOR NAME Johnson Funeral Home			ADDRESS W. Va. 25411			25a. DATE REC'D. BY REGISTRAR DEC 18 1979			25b. REGISTRAR'S SIGNATURE H. McElroy															

TD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, by the hospital or attending physician.



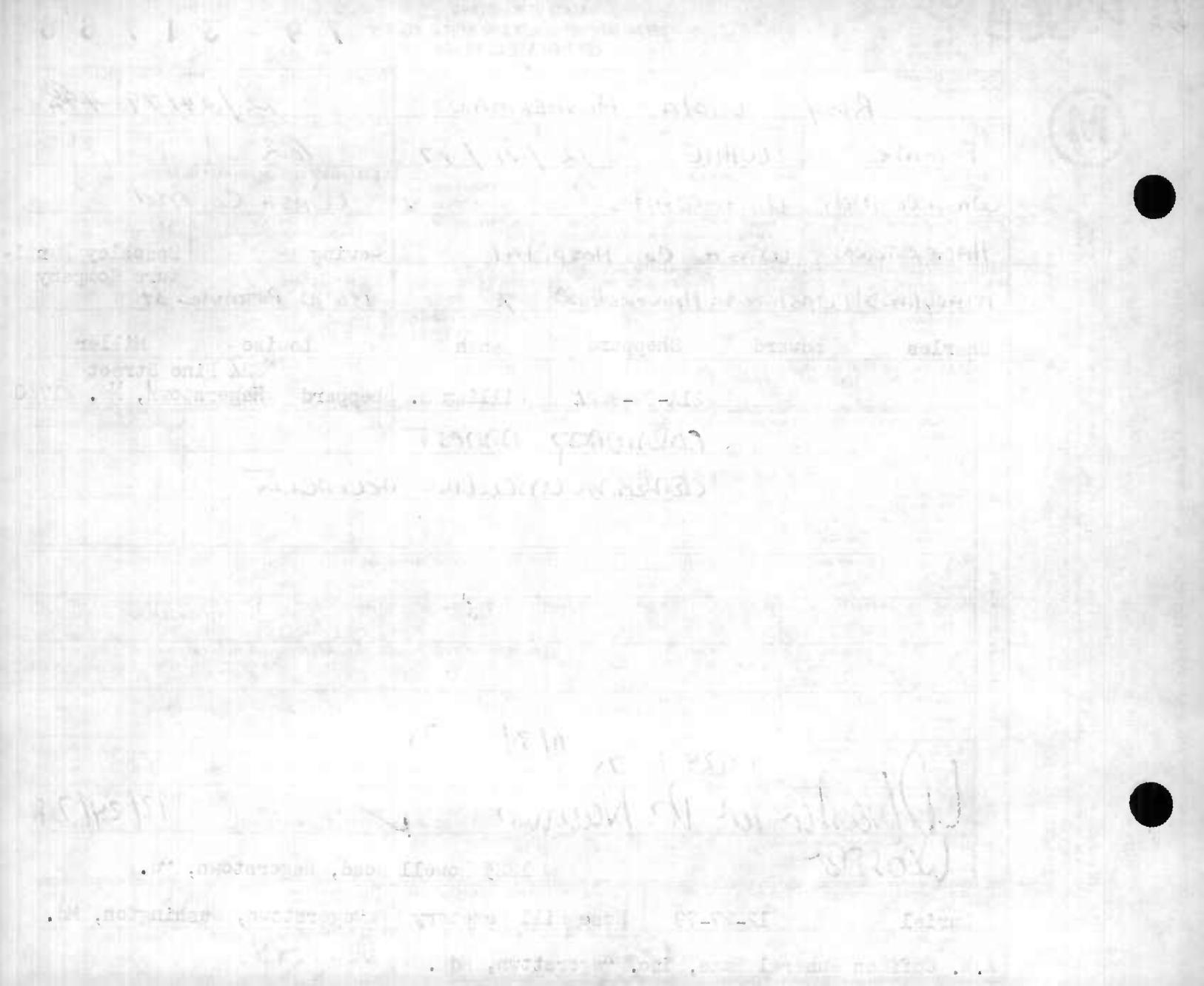
Page 4 may be filed within 72 hours after death.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH7 9 3 1 7 8 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Rosy Viola AUSHERMAN						12/24/79			4 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		WHITE		12/21/17			62 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Wash. Co. Md.		United States					Wash. Co. Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Wash. Co. Hospital			Sewing			Beachley Furniture Company				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Washington		Hagerstown					136 N. Potomac St.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. ADDRESS							
Charles Edward Sheppard		Sahah Louise Miller			824 Pine Street							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(YES, NO OR UNKNOWN)		214-09-9624		William R. Sheppard			Hagerstown, Md. 21740					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPATH</u> <u>2275</u>												
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC</u> <u>my</u> <u>vascular</u> <u>accident</u>												
} DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>12/29/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. DATE OF INJURY 11/31/79			22c. LOCATION CITY OR TOWN			COUNTY				
22d. SIGNATURE <u>Woolster for Dr. Nauman</u>		22e. DEGREE			22f. DATE SIGNED 12/24/79			STATE				
22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22h. ADDRESS										
22i. ADDRESS 1825 Howell Road, Hagerstown, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12-27-79		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN			23e. COUNTY		
24. FUNERAL DIRECTOR NAME A. K. Coffman Funeral Home, Inc.		ADDRESS Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			STATE		
				DEC 31 1979						<u>McAuliffe</u>		

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	9	
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
NELLIE MAY AUSTIN												Dec 24 1979						
3. SEX Female			4. RACE white			5. DATE OF BIRTH Sept 20 1901						6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.									
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Towers			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md			13b. COUNTY Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 11 Baltimore St. Potomac Towers									
14. FATHER'S NAME John			13c. CITY OR TOWN Ragers Town			15. MOTHER'S MAIDEN NAME Porsuch												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-30-9659			17. INFORMANT Leona Garrish, 113 N. Locust St.			ADDRESS Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myocardial Infarction Arteriosclerotic Coronary Disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 minutes 10 years												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus; Congestive Heart Failure																		
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Dec 22 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			22b. SIGNATURE Robert Brull			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 12/24/79						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull						22f. ADDRESS 1198 Kenly Ave. Hagerstown												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Dec. 27, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Broadfording Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland									
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740									25a. DATE REC'D. BY REGISTRAR JAN 2 1980			25b. REGISTRAR'S SIGNATURE Troy						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REF. NO.

31790

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH DAY YEAR			2b. HOUR							
Edna Mae Barger									<input checked="" type="checkbox"/> 12-26-79			19			5PM							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR						
Female	White	1 - 15 - 12		67						Dec. 26, 1979			7:30A			PM						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.						Washington County, MD			Hagerstown			1039 Florida Ave., Hag., Md.			Housewife					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME								
Maryland			Washington		Hagerstown						1039 Florida Avenue			Joseph			Nuse					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS													
No			219-05-2408			Mrs. Betty Harris, 105 E. Wash. St																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Coronary Arteriosclerosis Code 410															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY: 4140 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>															years							
(a) Arteriosclerosis Code 410 DUE TO, OR AS A CONSEQUENCE OF																						
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																						
(c) _____																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										2d. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																						
ACTUAL SIGNATURE		TITLE (SPECIFY) Howard N. Weeks, M.D.P.A. M.D. MEDICAL EXAMINER																DATE SIGNED Dec. 28, 1979				
EXAMINER'S NAME (TYPE OR PRINT)																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE										
Burial		12-29-79		Rest Haven Cemetery			Hagerstown, Wash., Md.															
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Rest Haven Funeral Chapel, Inc., Hag.,					MO DEC 31 1979																	

BP _____
DMMH - 17
(VR A15 ME (5
LMM 7/17)

DHMH-17
(VR A15 ME(5))
15M 7/77

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of the physician.

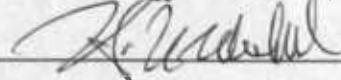
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7931791			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			26 HOUR			
JAMES DANIEL BARGER									12 13 79			10:45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
MALE		CAUCASIAN		04 25 02			77								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
CUMBERLAND		USA					Washington County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
HAGERSTOWN		WCH		RETIRED			Painter								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
MD		WA		HAGERS.			YES <input type="checkbox"/> NO <input type="checkbox"/>		RT. 4 BX 607 HAG.						
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
Theophilus				Mary Ellen Harrison			214-69-9611 Helen L. Barger			Route # 4 Box 607 Hagerstown, Md. 21740					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												3 days			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive heart failure</i>												one day			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>atherosclerotic heart disease</i>												years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from <i>12/12/79</i> to <i>12/13/79</i> , that (1) (we) last saw the deceased alive on <i>12/12/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) (did not) view the body after death.															
22b. SIGNATURE <i>Edson B. Moody</i>												22c. DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edson B. Moody												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. ADDRESS St. James Road, Hagerstown, Md.												22f. DATE SIGNED <i>12/14/79</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12-15-79		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Memorial Park, Hagerstown, Washington, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE								
24. FUNERAL DIRECTOR NAME <i>A. K. Coffman Funeral Home, Inc.</i> , Hagerstown, Md.												25e. DATE REC'D. BY REGISTRAR DEC 19 1979			
												REGISTRAR'S SIGNATURE <i>Henry M. Coffman</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 9 3 1 1 9 2				
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 24, 79 1979 PM									2b. HOUR 3:30				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			IF UNDER 1 YR. IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR 30 3PM				
Richard Floyd Barkley, Jr.						MONTH DAYS HOURS MIN.			Dec. 24 1979							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
Male		White		Oct. 6, 1947		32 yrs.		U.S.A.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) railroad			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1736 Crest Drive					
14. FATHER'S NAME Richard Floyd			15. MOTHER'S MAIDEN NAME Barkley, Sr. Betty								16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			17. INFORMANT ADDRESS Charles E. Barkley 12008 Hitching Rockville, MD post Lane		
											18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 410- IMMEDIATE CAUSE (a) Code 410 Acute Coronary DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN SUNSET AND hours		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> AM. MONTH DAY YEAR 2:20 P.M. Dec 24 1979			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto Accident (secondary to coronary)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Sherman Ave.			21f. LOCATION STREET CITY OR TOWN Sherman Avenue Hagers. Wash. MD			CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an			Autopsy <input checked="" type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input checked="" type="checkbox"/>			and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE 			M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED Dec. 26, 1979				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 580 Northern Ave. Hagers. MD													
23a. BURIAL/CREMATION/REMOVAL (SPECIFY) Burial			23b. DATE 12-28-79			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.			25a. DATE REC'D. BY REGISTRAR DEC 31 1979									25b. REGISTRAR'S SIGNATURE 				

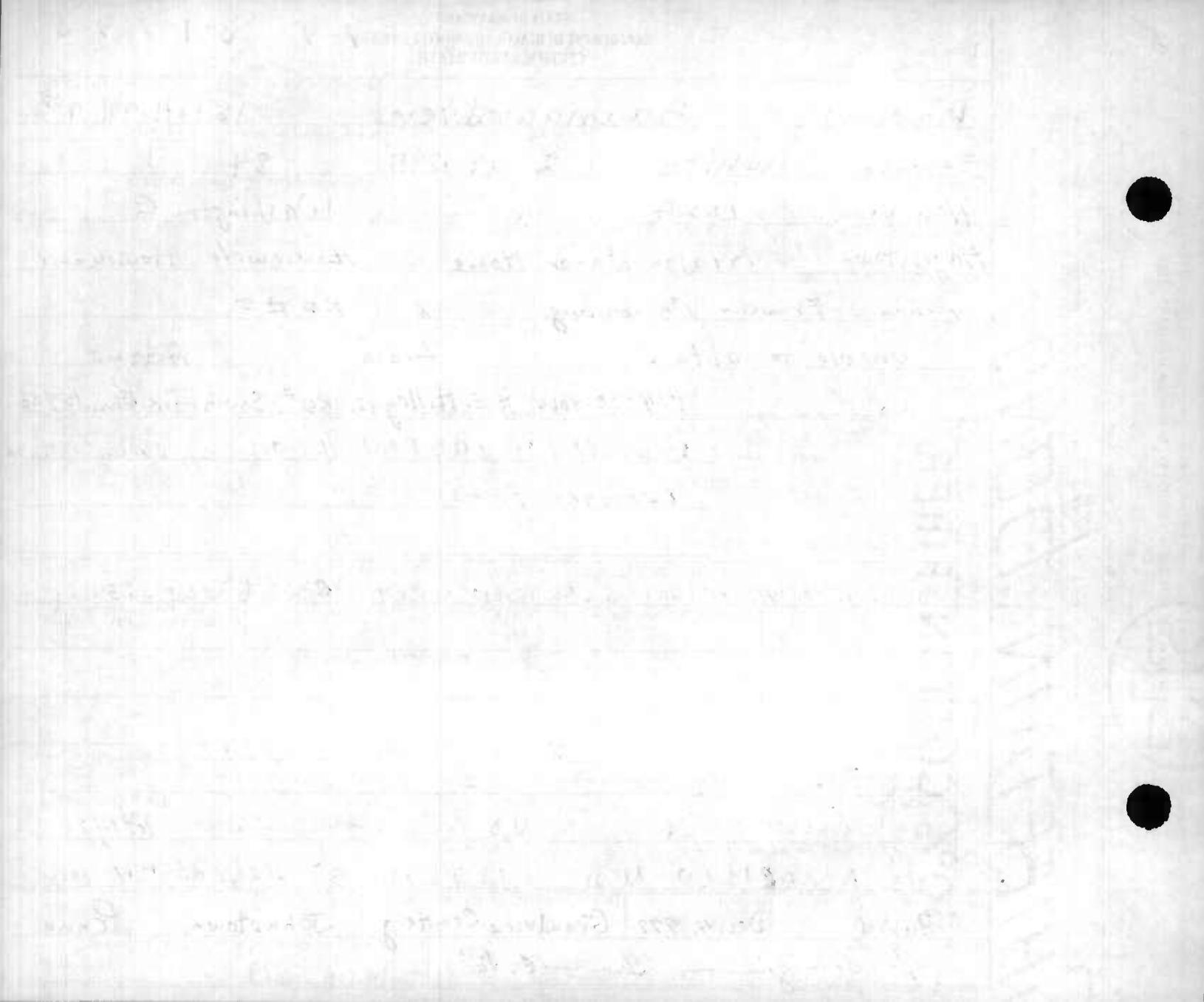
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - DECEASED NAME				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Marion Baumgardner							18	11	1979	7:05 AM		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)				7 IF UNDER 24 HRS	
Female		white		MONTH	DAY	YEAR	84	YEARS	MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH	
New York		U.S.A.					Washington, D.C.				Hagerstown	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Avalon Manor Home				Housewife				Housewife				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Penns.		Franklin		Chambersburg			YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Rd #5			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
		unable to obtain			Lidia					Adams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		174-50-9664		H.E. Hillegas, Rd #1, South Folk, Penn. 15956						LONG STANDING		
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												
2765 DYHYDRATION AND EMACIATION												
DUE TO, OR AS A CONSEQUENCE OF (b) EEFICIAL TO EAT												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/4/1979 to 11/30/1979, that (I) (we) lost sow the deceased alive on 11/30/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE					DEGREE			22c. DATE SIGNED				
					M.D.			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	12/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		12. AMARILLO M.D.			127 KING ST HAGERSTOWN MD			22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY	23f. STATE		
Burial		Dec. 4, 1979		Grandview Cemetery			Johnstown		Penns.			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Janell Zinner		126. Pa			DEC 6 1979		Lily McCreedy					



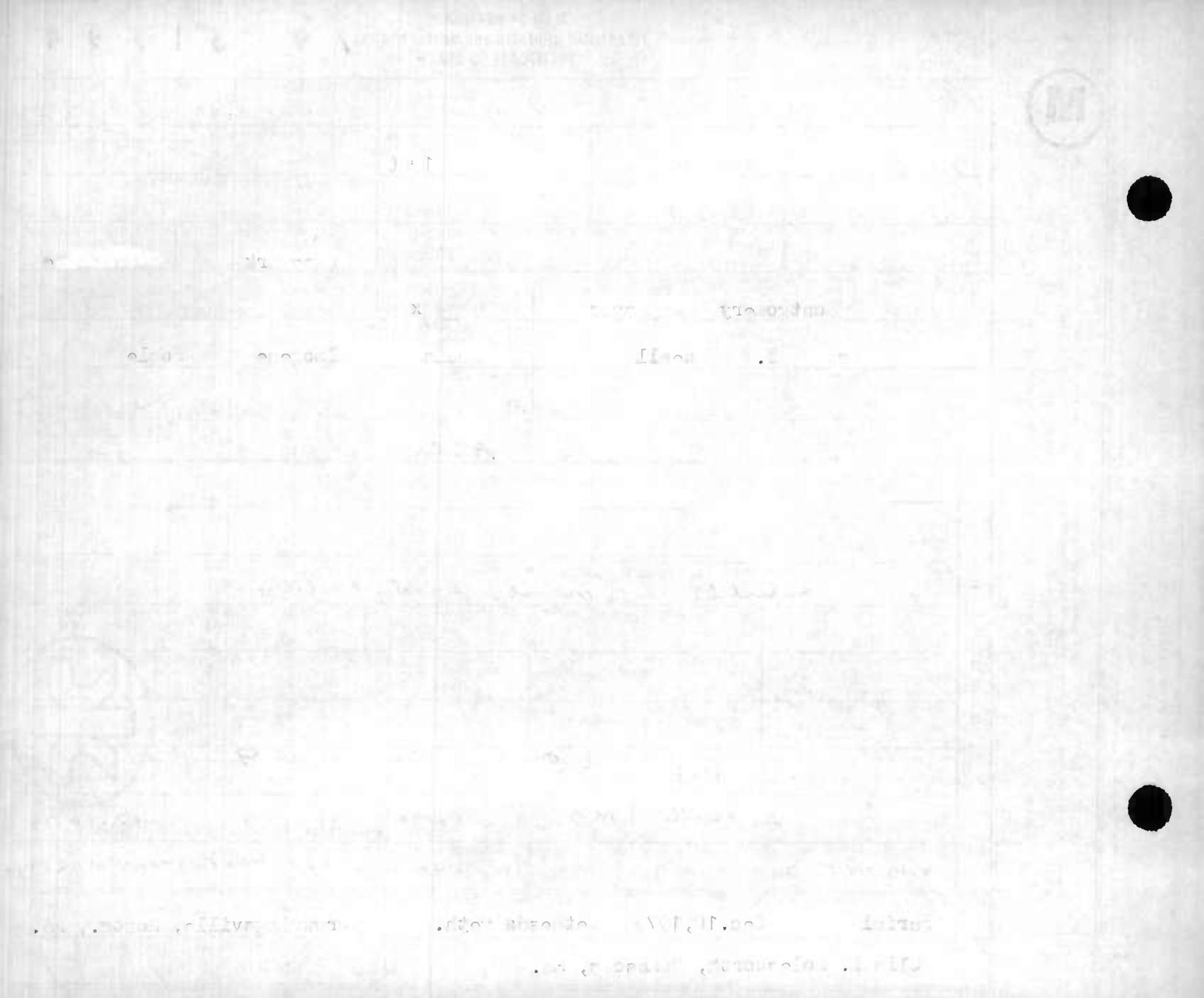
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
7 9 3 1 7 9 4 .											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Virgie B. Beall					Beall	12-8-79					1979	8 A.M.	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female			White		11-09-1900			79			IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
35 Maryland			U.S.A.						Washington County MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
90 Hagerstown			Cotton Villa Nursing Home			Housework			Own home				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
35 Maryland			Montgomery		Damascus					Damascus 20107 27456 Clarksburg Rd, Md.			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Edward T. Beall						Louis Imogene Poole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			None			219-54-0325 Mr. Clark King			8803 Main St., Damascus Rd.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4292</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs													
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>metastatic ca of breast, dehydrated, malnourished</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> , 19 <u>26</u> , to <u>12-8</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>11-8</u> , 19 <u>73</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Vasant Datta</u> MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-10-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, M.D.			22e. ADDRESS 1600 OAK HILL AVE, HAGERSTOWN, MD 21740										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 10, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Bethesda Eth.			23d. LOCATION CITY OR TOWN Browningsville, Montg., Md.			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <u>Olin L. Molesworth, Damascus, Md.</u>			25a. DATE REC'D. BY REGISTRAR DEC 13 1979			25b. REGISTRAR'S SIGNATURE <u>John Murphy</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must initial and date this section.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 7 9 5					
										REG. NO.					
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
			Mabel Gertrude BEARD						December 22, 1979					1025 A M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		July 2, 1886			93 YRS		MONTHS DAYS		HOURS MIN				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.						Washington							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Garlock Nursing Home			housewife										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a STREET ADDRESS					
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		233 Shadybrook Terrace							
14 FATHER'S NAME FIRST Henry			MIDDLE J.		LAST Stouffer		15 MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE A.		LAST Summers				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS						
no			213-74-4986			Mrs. Rosannah Hoover, Hagerstown, Maryland									
18 CAUSE OF DEATH (Enter only one cause per line for part 1a, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4140 <i>atherosclerotic heart disease</i>															
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>April 11</i> , 1978, to <i>Dec 22</i> , 1979, that (I) (we) last saw the deceased alive on <i>Dec 3</i> , 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.															
22b SIGNATURE <i>Adrienne Rosenblum</i>		22c DEGREE <i>MD</i>		22d ATTENDING PHYSICIAN		22e MEDICAL DIRECTOR		22f STAFF PHYSICIAN		22g DATE SIGNED <i>12-24-79</i>					
22f PHYSICIAN'S NAME (TYPE OR PRINT)															
22g ADDRESS <i>514 E. WILSON BLVD., HAGERSTOWN, MD</i>															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
Burial		Dec. 27, 1979		Rose Hill Cemetery			Hagerstown, Wash., Maryland								
24 FUNERAL DIRECTOR NAME <i>Minnich Funeral Home</i>										25a. DATE REC'D. BY REGISTRAR <i>JAN 2 1980</i>					
ADDRESS <i>415 E. WILSON BLVD., HAGERSTOWN, MARYLAND 21740</i>										25b. REGISTRAR'S SIGNATURE <i>Adrienne Rosenblum</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	3	1	7	9	6
1 - FOR STATE REGISTRAR				REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR						
Virginia		R.		Benner.	12-3-79						M						
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS				
Female		White		13 13 06			72 yrs			MONTHS			DAYS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			12b KIND OF BUSINESS OR INDUSTRY				
West Virginia		US of								Washington County MD			public school				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Avalon Manor.										teacher					
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS							
Maryland		Washington		Hagerstown						4 Marbern Road							
14 FATHER'S NAME FIRST		MIDDLE		LAST	15 MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST						
Edgar Ricamore					Louise Gaster												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS										
No		219-36-3757		Mr. Joe Hartle, Hagerstown, Md.													
18 CAUSE OF DEATH (Enter only one cause per line for (1), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>																	
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease</u> (?) (c) <u>Diabetes Mellitus</u> (?)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>11-23</u> , 19 <u>79</u> , to <u>12-4</u> , 19 <u>79</u> , that (I) <u>we</u> last saw the deceased alive on <u>11-29-</u> 19 <u>79</u> and that in (my) <u>we</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did not</u> <u>view</u> the body after death.																	
22b. SIGNATURE <u>Lloyd A. Hoffman</u>					DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL STAFF DIRECTOR <input type="checkbox"/>		PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-4-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lloyd A. Hoffman</u>					22e. ADDRESS <u>1147 0212 Hill Ave</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 6, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery			23d. LOCATION CITY OR TOWN Sharpsburg, Wash., Maryland		COUNTY		STATE					
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740								25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE <u>John McElroy</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7931797					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
John			Eldon			BISHOP, Sr.						December	6	1979		10:20A M	
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)	7. # UNDER 1 YEAR	8. # UNDER 24 HRS			
Male			White			MONTH Nov. 1, 1917 DAY YEAR						62	YRS	MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania			U.S.A.									Washington County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown			Washington County Hospital			Guard			M. C. I.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Washington			Hagerstown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. #6 Box 126					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
James			S			Bishop			Rose			Lynch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS								
Yes			W.W. 11			417-12-1602			Thelma V. Bishop			same as 13.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410- Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last												18 hrs					
DUE TO, OR AS CONSEQUENCE OF (b) Myocardial Infarction												11/14/79					
DUE TO, OR AS CONSEQUENCE OF (c) Arteriosclerotic heart disease												10/12/64					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/12/79 to 12/6/79, that (I) (we) lost saw the deceased alive on 10/12/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (do not) view the body after death.												22b. DATE SIGNED					
22c. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
Donald E. Martin, M.D.			363 S. Cleveland Ave Hagerst														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE					
Burial			12-9-79			Mays Chapel			Warfordsburg			Fulton Pa.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Katherine J. Stone Hancock MD									DEC 12 1979			Linda McBrady					

4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

31798
REG. NO.

1- STATE REGISTRAR			9																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR 11:00 P M					
Ruth			Satler			BIXLER						<input checked="" type="checkbox"/> Dec 10 1979								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD			2d. HOUR 2d HOUR 2155 P M				
female		white		Sept. 13, 1890			89						12 11 1979							
10. BIRTHPLACE (STATE OR PROVINCE, U.S.A.)			7b. CITIZEN OF WHAT COUNTRY?			USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Washington					
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			28 S. Canon Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			home maker			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown																				
13. STATE Maryland			14. COUNTY Washington			15. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 28 S. Canon Ave.								
14. FATHER'S NAME William H. Bixler						15. MOTHER'S MAIDEN NAME Emma E. Satler														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Kenneth Snapp, Hagerstown, Md.								
no																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebrovascular accident 433</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate					
436- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																				
(b) <i>hypertension 401</i>															yes					
(c) <i>cerebrovascular arterosclerosis 440</i>															yes					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <i>Ruthven Ruth Bixler</i>						TITLE (SPECIFY) M.D. ASST			MEDICAL EXAMINER			DATE SIGNED <i>12/13/79</i>								
EXAMINER'S NAME (TYPE OR PRINT)			Hazel R. Tritch Jr.			ADDRESS 138 E. Antietam ST.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec. 14, 1979			23c. NAME OF CEMETERY OR CREMATORIY Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Md.			COUNTY			STATE					
burial																				
24. FUNERAL DIRECTOR NAME <i>Minnich Funeral Home</i> 415 E. Wilson Blvd., Hagerstown, Md.									25a. DATE REC'D. BY REGISTRAR <i>DEC 17 1979</i>			25b. REGISTRAR'S SIGNATURE <i>Patricia McHenry</i>								
BP																				

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9 3 1 1 9 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Nellie	MIDDLE Shank	LAST Bowers	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH DECEMBER	DAY 29	YEAR 1979	2b. HOUR 1:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1892	6. AGE (IN YEARS LAST BIRTHDAY) 87	7. IF UNDER 1 YR. MONTHS 87	8. IF UNDER 24 HRS. DAYS 0	9. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec 29 1979	10. HOUR 1:55 P.M.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boliver, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) Downsville Pike			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13. STATE Maryland		14. COUNTY Frederick	13c. CITY OR TOWN Middleton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2112 Old National Pike					
14. FATHER'S NAME FIRST John		MIDDLE Jacob	LAST Shank	15. MOTHER'S MAIDEN NAME FIRST Clara		MIDDLE Virginia	LAST Harp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-28-1306		17. INFORMANT Mrs. Lana C. Cobb,		ADDRESS 9505 Fern Hollow Way Gaithersburg, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured thoracic aorta 869 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Ruptured myocordium instant DUE TO, OR AS A CONSEQUENCE OF (c) automobile accident E 815										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Crushed thorax										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto Accident						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Harold R. Tritch Jr.</i>		TITLE (SPECIFY) M.D. <i>asst</i>			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Harold R. Tritch		ADDRESS 138 E. Arctic Tam ST			DATE SIGNED 12/31/79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-1-80		23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery			23d. LOCATION CITY OR TOWN Middleton, Fred. Co., Md.		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.		ADDRESS Boonsboro, Md. 21713			25a. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE <i>George McCreary</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 18 FOR FUTURE USE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Section 9.2: The Pythagorean Theorem

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7931800						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
HAZEL MARY BREWER			BREWER			DEC 8 - 1979			9 P.M.									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female		White		Month Day Year			83			MONTHS		DAYS		HOURS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Maryland		U.S.A.		April 12, 1896			Washington County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Ravenwood Lutheran Village		Housewife														
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												14. INSIDE CITY LIMITS?						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. ADDRESS						
Maryland		Washington		Hagerstown					1911 Virginia Avenue			102 Hampton Road West						
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			MIDDLE		LAST		Williamsport, Md. 21795					
John				Forsyth		Rebecca					Shipp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No		217-32-5457		Mrs Mary L. Jacobs														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												4140						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												a chronic & debilitating disease						
DUE TO, OR AS A CONSEQUENCE OF (b)												4140						
DUE TO, OR AS A CONSEQUENCE (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												Debility, Diabetes						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/3 1979 to 12/8 1979, that (I) (we) last saw the deceased alive on 11/3 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body of the deceased.												22b. DATE SIGNED 12-10-79						
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
S. D. REY ROSENSTEIN M.D.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
Burial		12-12-79		Rose Hill Cemetery			Hagerstown, Washington, Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				DEC 13 1979														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 3 1 8 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
RUTH Barton BUTCHER				12-22-79				3:30 pm	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE	CAUCASIAN	MONTH	DAY	1900	78	MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) XXXXX-XXXXXX-XXXXXX.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 306 GROVE BLVD.	
14. FATHER'S NAME FIRST: Hardy		MIDDLE: Hill	LAST: Barton	15. MOTHER'S MAIDEN NAME FIRST: Minnie		MIDDLE:		LAST: Kennedy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT BEVERLY BYRON		ADDRESS 306 GROVE BLVD FREDERICK, MD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH m	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis yes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Nov 1, 1976</u> to <u>12-22-79</u> , that (1) (we) last saw the deceased alive on <u>12-16-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Vasant Datta		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-24-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, M.D.		22e. ADDRESS 1600 OAKHILL AVE, HAGERSTOWN, MD 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 24, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Cemetery		23d. LOCATION Shippard, Pr. Geo's, Maryland			
24. FUNERAL HOME NAME Shirley, Fadley, Keeney, Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		ADDRESS Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE moyne ready			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit report. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			December 27, 1979			7:30 A				
Woodrow W. Cronise																
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			October 4, 1913			66			MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.	
Appleton, Md.			U. S. A.									Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington County Hospital						Carnival Rides Operator							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Washington			Boonsboro						Rfd. 1 Box 75				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
Esby			Cronise												Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No.			214-90-5708			Mrs. Virginia M. Cronise,			Rfd. 1 Box 75			Boonsboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Poverty & infirmity & squamous cell</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>1639</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>carcinoma of lung -</i> (c) <i>Diabetes mellitus</i>															17 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-8- -</i> , 19 <i>65</i> , to <i>12-1- -</i> , 19 <i>78</i> , that (I) (we) last saw the deceased alive on <i>12-1- -</i> , 19 <i>78</i> , and that in (my) <i>last</i> opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <i>John J. Secondari</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>12-27-79</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH SECONDARI</i>			22e. ADDRESS <i>Boonsboro 21713</i>													
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>12-29-79</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Boonsboro Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Boonsboro, Wash. Co., Md.</i>			COUNTY		STATE		
24. FUNERAL DIRECTOR <i>John H. Bast, Jr.</i>			ADDRESS <i>Boonsboro, Md. 21713</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 31 1979</i>			25b. REC'D. IN REGISTRAR'S SIGNATURE <i>John H. Bast, Jr.</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner/must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	3	1	8	0	3
										REG. NO.						
1 - STATE REGISTRAR			Carrie Edith Davis													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Carrie Edith Davis								12 20 79				11 ¹⁰ PM				
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. DATE REC'D. BY REGISTRAR		IF UNDER 1 YEAR		IF UNDER 24 HRS				
F		Cauc.		MONTH 8 DAY 20 YEAR 1899		80 YRS		DEC 27 1979		MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH										
Maryland		U.S.A.				Washington County										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
Hagerstown		Pawneewood		Housewife												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS								
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		35 N. Cleveland Avenue								
14. FATHER'S NAME		FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.								
		Cleggett		Bowers		Sarah		220-05-6008								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		- - -		Mrs. Rosalyn L. Dale		Acute Myocardial infarct		Rt. #2 Box 111 Williamsport, Md.		30 Minutes.						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		ASHD.		years.										
410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any		DUE TO, OR AS A CONSEQUENCE OF (c)		AS hypertension obsrv		years.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11/18/79, 19 75, to 12/20/79, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				9-5-78												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR OF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED										
Dr. M. Milaninia		D.O.				12/21/79										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		1500 Penna. Ave., Hagerstown, Md.												
Dr. M. Milaninia																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
Burial		12-24-79		Rose Hill Cemetery		Hagerstown		Washington		Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS		40 E. Antietam		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
A. K. Coffman Funeral Home, Inc.		Hagerstown, Md.		DEC 27 1979		H. McAleny										

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR					
1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR					
Roberta NMN Dayhoff								12 30 79				7 23 A.M.					
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
Female		White		4 18 1896				83 YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 DATE				9 BALTIMORE CITY OR COUNTY OF DEATH				MD.					
Virginia		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Washington									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County Hospital				housewife											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Washington		Hagerstown		YES <input type="checkbox"/>		1138 Security Road									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO				16b. SOCIAL SECURITY NO 214-74-3036				17. INFORMANT ADDRESS Mr. Kenneth Dayhoff, Hagerstown, Maryland			
Charles				Lillian Clark												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days.	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF (b)				DUE TO, OR AS A CONSEQUENCE OF (c)									
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)				Central Thombus.				Cerebral Thombus.								10 yrs.	
																2 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (i) (this hospital) attended the deceased from 2-6, 1970, to 12-30, 1979, that (ii) (we) last saw the deceased alive on 12-30, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) did (did not) view the body after death														22c. DATE SIGNED 19-30-79.			
22b. SIGNATURE Charles		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery				23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland				23e. COUNTY STATE					
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 N.E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR JAN 4 1980				25b. REGISTRAR'S SIGNATURE Loyalty McCreary							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	0	5
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Ralph Eugene DEVORE						12			9	79		5:35 P.M.						
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS							
male			white	MONTH Oct. 18, 1907 DAY YEAR		72			MONTHS YRS.		MONTHS DAYS HOURS MIN							
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland			USA					Washington										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Hagerstown			930A Lanvale St.		2nd floor			press operator			aircraft mfg.							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			930A Lanvale St.									
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	16. ADDRESS									
Jesse E. DeVore					Amy E. Moreland				Mrs. Pauline Spidell, Hagerstown, Md.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
no			214-09-1874		Mrs. Pauline Spidell, Hagerstown, Md.			minutes										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)																		
acute myocardial infarction																		
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any																		
DUE TO, OR AS A CONSEQUENCE OF (b) arteriovenous heart disease																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (the hospital) attended the deceased from March 18, 1978, to Dec. 9, 1979, that (I) (we) last saw the deceased alive on 10-19 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.																		
22b. SIGNATURE Harold Twitchell M.D. for Detto III			DEGREE M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/79								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 138 E Courtland St Hagerstown Md															
HAROLD Twitchell																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			STATE								
burial			Dec 12, 1979		Rose Hill Cemetery		Hagerstown, Md.											
24. FUNERAL DIRECTOR Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md.												25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE Hector DeBenedictis				

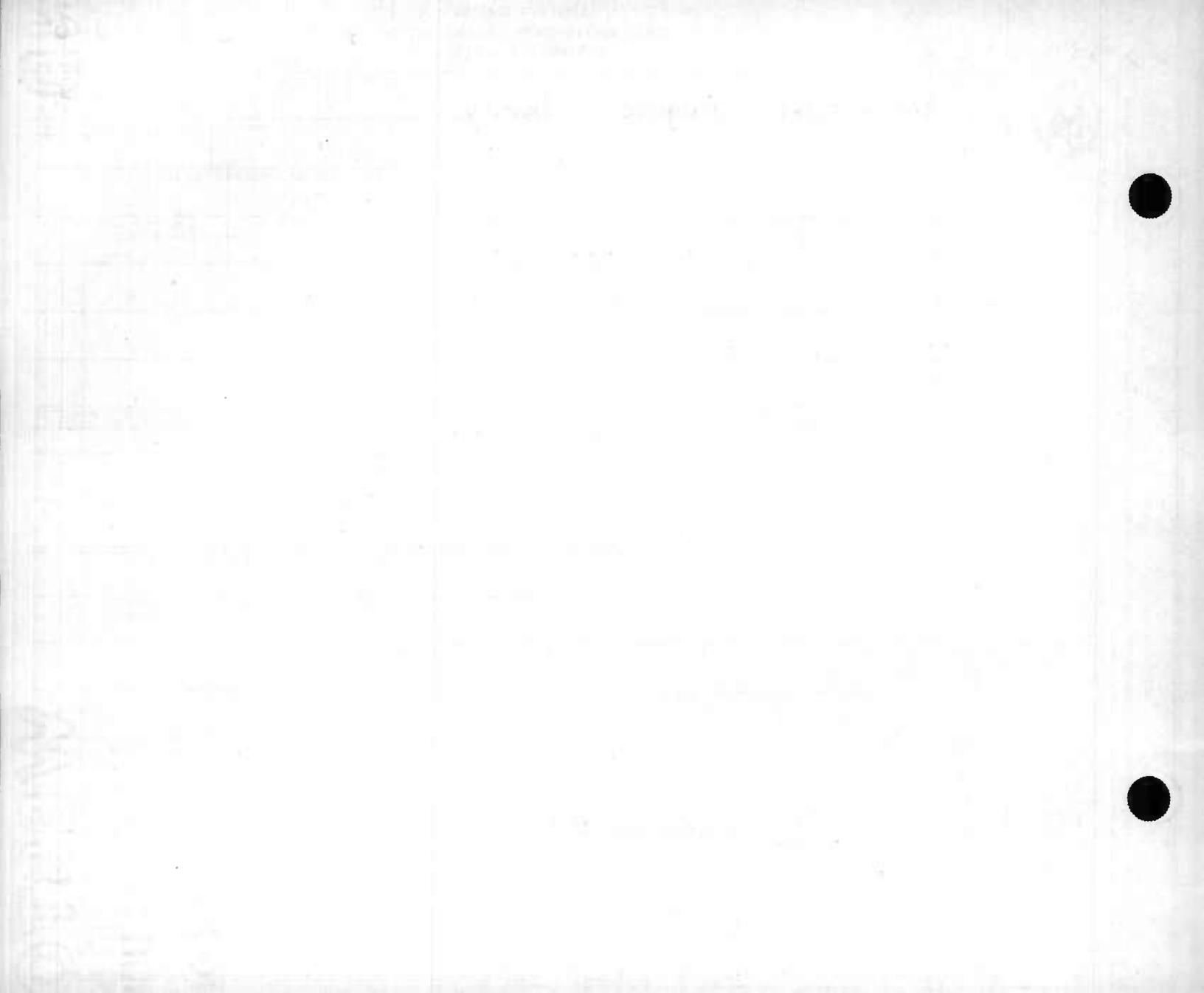
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Dorse Earl				Eugene		Dorsey	12/16/79				7:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		IF UNDER 24 HRS	
male		white		MONTH DAY YEAR June 9, 1917			62		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA					Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Washington County Hospital		welder				railroad				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		209 West Side Avenue				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS					
		Harry C.	Dorsey		Anna C. Dietrich		Margaret Dorsey, Hagerstown, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		705-10-6195		Margaret Dorsey, Hagerstown, Md.								
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESP ARREST												
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) congestive heart failure - (c) coronary artery disease												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/16/79 to 12/16/79 , that (I) (we) last saw the deceased alive on 12/16/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Dorothy Wooster MD		22c. DEGREE MD		22d. ADDRESS 1825 Howell Rd Hagerstown MD -		22e. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED 12/16/79				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 10, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE Dorothy Wooster						
DHMH-16 20M (VRA 15, 4) 7/78												



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

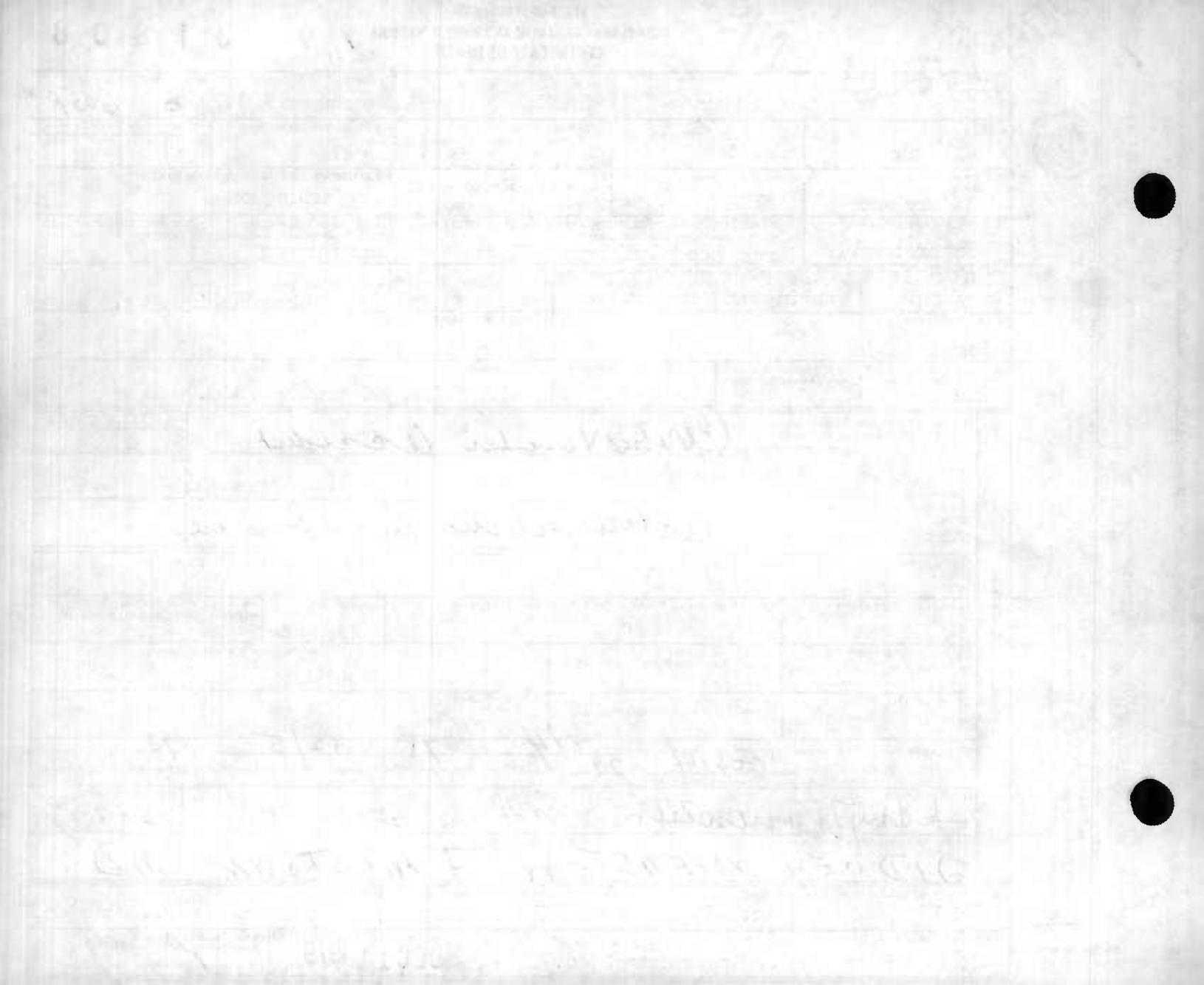
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 0 7				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
SAMUEL DANIEL DUSING												12/1/79				4:18 P
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
male			white			MONTH DAY YEAR Sept. 7, 1904			75			MONTHS	YEARS	MONTHS	HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.						Washington							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington County Hospital			laborer			Contractor							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Wash			Hagerstown						57 S. Potomac, St.				
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			LAST				
Joseph						Dusing			Ella			Forrest				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no			214-16-0682			Coffman Home For The Aging Hagerstown, Md.						48 hrs.				
18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (10) <u>Gastro Intestines hemorrhage</u>															24 hrs	
4292 Conditions, if any, which gave rise to immediate cause (10), stating the underlying cause, lost. (b) <u>Cerebral Anoxia</u>															15 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10 <u>Diabetes Mellitus.</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) this hospital attended the deceased from 12-10, 1979, to 12-1, 1979, that (1) (we) last saw the deceased alive on 12-1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.															22c. DATE SIGNED 12-2-79	
22b. SIGNATURE <u>Charles F. Hens</u> M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles F. Hens M.D.</u>			22e. ADDRESS <u>Smithsburg Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Dec. 5, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Bethel Cemetery			23d. LOCATION CITY OR TOWN Foxville, Fred. Md.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME									25a. DATE REC'D. BY REGISTRAR DEC 7 1979			25b. REGISTRAR'S SIGNATURE <u>John McBrady</u>				
Davis Funeral Home																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 0 8			
												REG. NO.			
1 - STATE REGISTRAR															
I DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Anna Mary EAKLE						December 5, 1979			10			6:05 P M			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS		
female			white		MONTH DAY YEAR			87			MONTHS DAYS		HOURS MIN		
Sept. 24, 1892									YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			USA					Washington							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Ravenwood Lutheran Village		seamstress										
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland			Washington		Hagerstown			YES <input type="checkbox"/> NO <input type="checkbox"/>			1918 Lincolnshire Ave.				
14. FATHER'S NAME			FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			17. INFORMANT				
Josiah Eakle					Mary Stickle			214-09-7207			Anita White, Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crush Vascular Accident</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)															
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
			P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> , 19 <u>78</u> , to <u>12/5</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Oct 14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>John W. Moore</u>			22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>12-7-79</u>						
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. D. REY MOORE</u>			22g. ADDRESS <u>Funkstown MD.</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Dec. 8, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland			COUNTY		STATE	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>												25a. DATE REC'D. BY REGISTRAR <u>DEC 11 1979</u>		25b. REGISTRAR'S SIGNATURE <u>John W. Moore</u>	



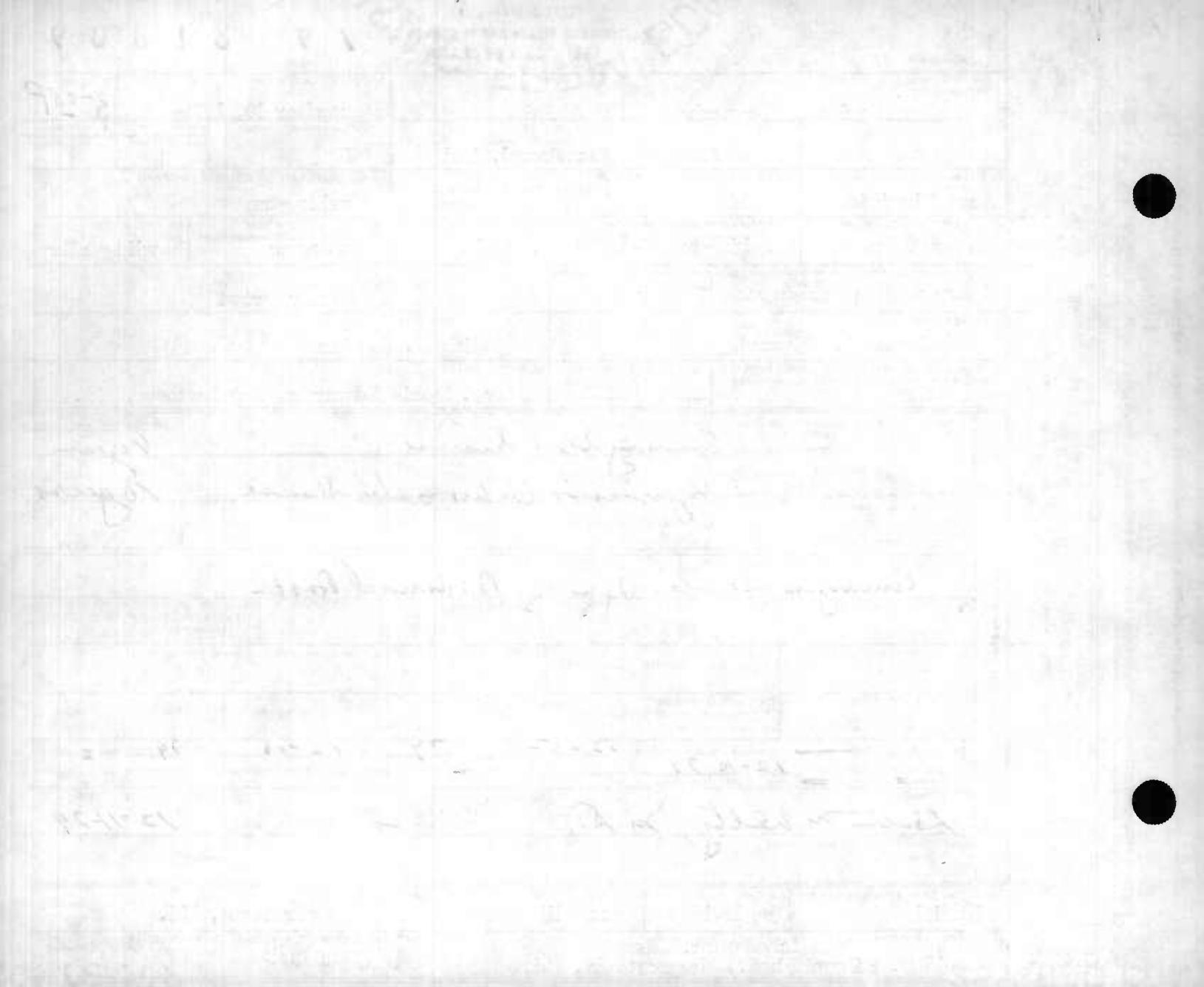
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	3	1	8	0	9
										REG. NO.						
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR						
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST				December 10, 1979			5-05P M			
Rufus Kennedy Edwards																
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
male		white		MONTH DAY YEAR October 1, 1901				78 YRS.		MONTHS DAYS		HOURS MIN				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH								
West Virginia		USA						Washington MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Washington County Hospital								manager		bowling alley				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?				30 Manor Drive						
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
James F. Edwards						Edith B. Rowland										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS							
NO			213-18-9363			Mrs. Doris Edwards, Hagerstown, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>										4 years						
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										10 years						
DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Hypertension</u> <u>Coronary Artery Disease</u>																
DUE TO, OR AS A CONSEQUENCE OF: (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (His hospital) attended the deceased from 12-5-1979 to 12-10-1979, that (we) lost saw the deceased alive on 12-10-1979, and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.																
22b. SIGNATURE <u>John M. Kelly, M.D.</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-11-79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec 13, 1979			23c. NAME OF CEMETERY OR CEMETORY Rose Hill Cemetery				23d. LOCATION CITY OR TOWN Hagerstown, Md. COUNTY STATE						
burial																
24. FUNERAL DIRECTOR NAME Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md.						25a. DATE REC'D. BY REGISTRAR DEC 14 1979				25b. REGISTRAR'S SIGNATURE <u>John M. Kelly</u>						

BP

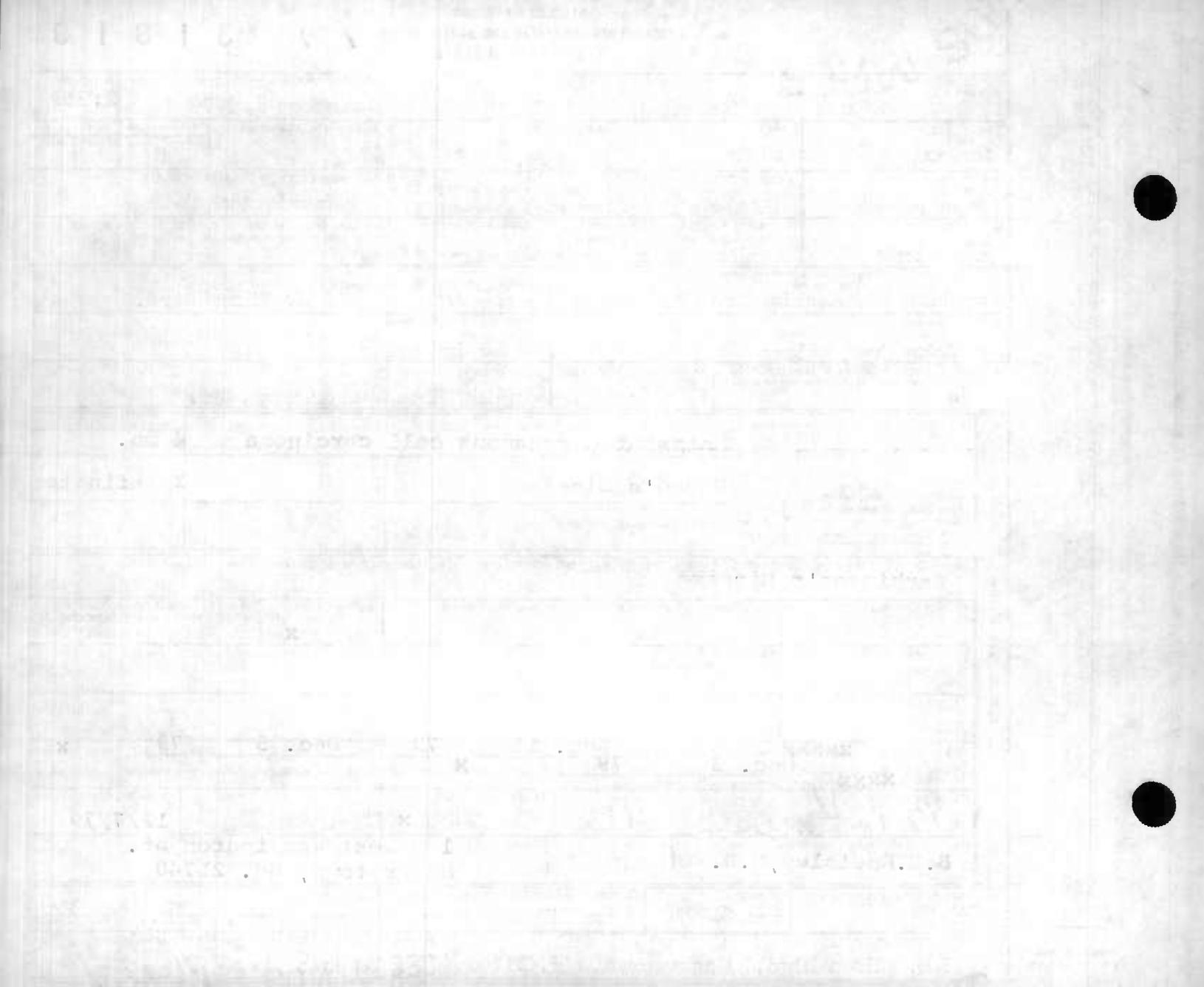


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			December 5, 1979			2:35P	
Ruth Elizabeth EHLERS																
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
				June 20, 1905			74			YRS.		MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.						
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland		13b. COUNTY Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 212 W. Wilson Blvd.									
14 FATHER'S NAME John Fred Ehlers		15 MIDDLE		16. MOTHER'S MAIDEN NAME Lydia Waring			17 INFORMANT ADDRESS Judith Kline, Hagerstown, Md.									
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO 214-09-0100A		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MO.												
18d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18e. DUE TO, OR AS A CONSEQUENCE OF Bowen's Disease (b)		18f. DUE TO, OR AS A CONSEQUENCE OF (c)			18g. Indefinite									
18h. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Parkinson's Disease																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN									
22a. I certify that (I) <input type="checkbox"/> (we) <input checked="" type="checkbox"/> attended the deceased from Aug. 15, 1979, to Dec. 5, 1979, that (I) <input type="checkbox"/> (we) <input checked="" type="checkbox"/> last saw the deceased alive on Dec. 3, 1979, and that in (my) <input type="checkbox"/> (our) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input checked="" type="checkbox"/> did not view the body after death.																
22b. SIGNATURE B.B. Kneisley, M.D.		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 12/7/79									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) B.B. Kneisley, M.D.		22f. ADDRESS 148 West Washington St. Hagerstown, Md. 21740														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 8, 1979		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland									
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE Loring McElroy												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	1	1		
												REG. NO. 7931811								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
JESSIE BELLE FRATIANNI												12 7 79						3:55 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
F			W			MONTH 2 DAY 21 YEAR 96			83 YRS.			MONTHS			DAYS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Maryland			USA						Washington			Washington								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown			Washington Co. Hospital			housewife			housewife			home								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			134 N. Locust St.								
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
Jacob			—			Miller						Anna Belle Koontz								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
NO			214 54 0553			Marguerite O. Eberly			615 Pa. Ave			1 WEEK								
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c).)																				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>multiple pulmonary emboli</u>																				
4157 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																				
DUE TO, OR AS A CONSEQUENCE OF (b)																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																				
Non cardiogenic pulmonary edema, (2) organic heart disease																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11:30, 19 79, to 12:17, 19 79, that (I) <input type="checkbox"/> last saw the deceased alive on 12:17, 19 79, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.																				
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
Mary E. Money MD												12.7.79								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			1198 Kenly Ave. Hagerstown														
Mary E. Money																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
Burial			12-11-79			Rose Hill Cemetery			Hagerstown			Maryland								
24. FUNERAL DIRECTOR NAME			ADDRESS			305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Gerald N. Minnich			Hagerstown, Md.			DEC 17 1979						Mary Money								

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

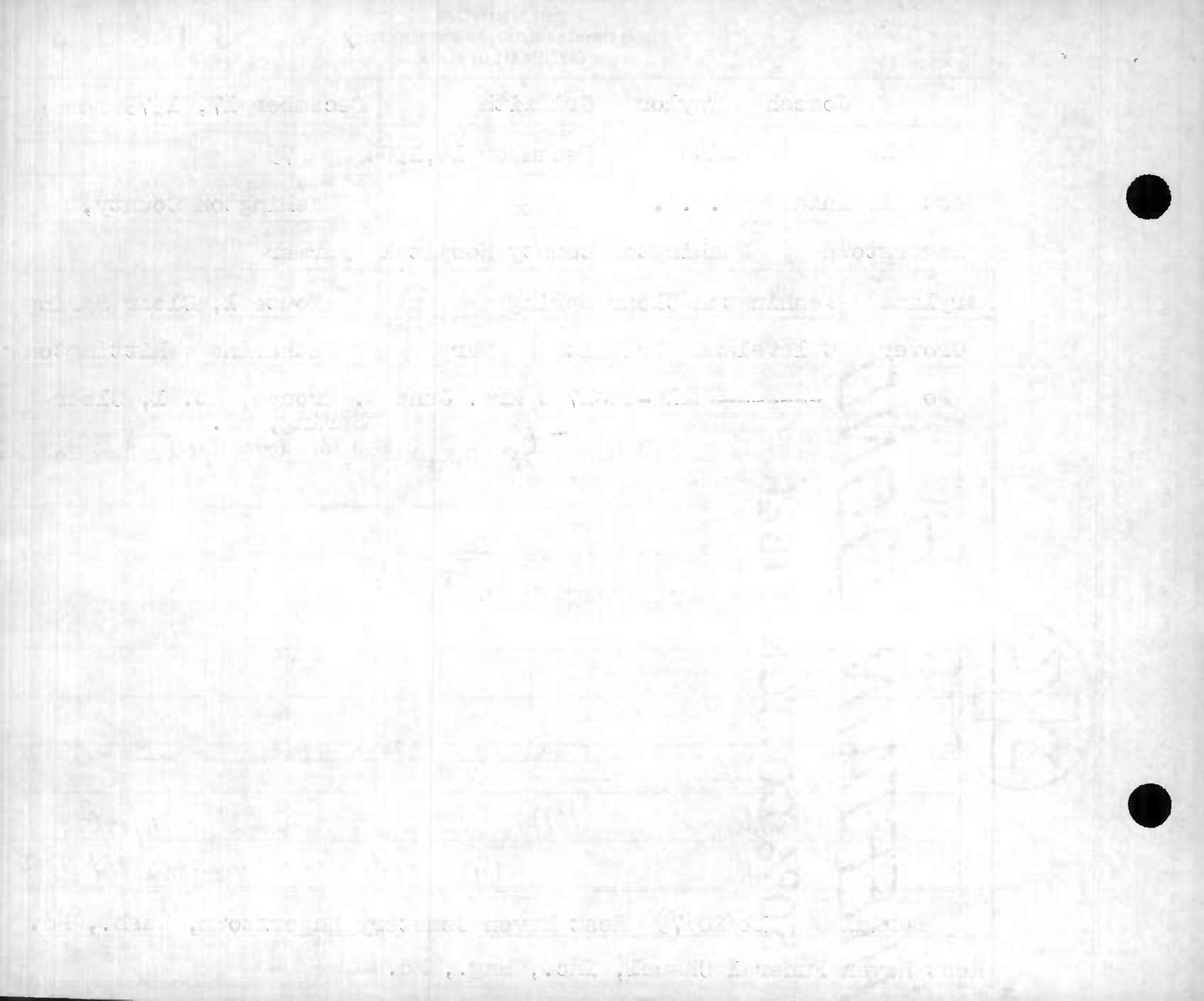
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31812		
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Lawrence GIORDANO, Jr.						2a. DATE KNOWN OF DEATH ESTI- MATED 12-9-1979			2b. HOUR MONTH DAY YEAR 12-9 1979 6:00 P		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec 9 1953		6. AGE (IN YEARS LAST BIRTHDAY) 26 yrs.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 12-10-1979				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Washington						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Co. Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) assembly			12b. KIND OF BUSINESS OR INDUSTRY truck mfg.			
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Broadway						
14. FATHER'S NAME FIRST Lawrence			MIDDLE Giordano		LAST Sr.		15. MOTHER'S MAIDEN NAME FIRST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. SOCIAL SECURITY NO. 162-46-2643		17. INFORMANT L. Giordano, Sr. Waynesboro, Pa.			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>death by hanging</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
9530 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									2d. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Harold R. Tritch</i>			TITLE (SPECIFY) M.D. <i>assistant</i> MEDICAL EXAMINER									DATE SIGNED <i>12-11-79</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>Harold R. Tritch MD</i>			ADDRESS <i>1386. ANTETAM ST HAGERSTOWN MD.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12-14-79		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery				23d. LOCATION CITY OR TOWN South Plainfield, N. J.		23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>Minnich Funeral Home</i>			ADDRESS 415 E. Wilson Blvd. Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1979			25b. REGISTRAR'S SIGNATURE <i>Harold R. Tritch</i>						
BP		DHMH-17 (VR A15 ME (5)) 30M 7/73												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbonpap. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
Joseph Taylor Griffith						December 17, 1979					12:00 A.M.						
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male	White		December 14, 1904			75		YRS	MONTHS	DAYS	HOURS MIN						
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.									
West Virginia	U.S.A.																
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Hagerstown	Washington County Hospital			Farmer													
13a. STATE Maryland										13b. COUNTY Washington		13c. CITY OR TOWN Clear Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Clear Spring	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
Grover C. Cleveland Griffith			Mary Katherine Whittington														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		218-24-1720		Mrs. June C. Troupe, Rt. 1, Clear													
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Spring, Md.							
2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost										Malignant Lymphoma, well differentiated type							
DUE TO, OR AS A CONSEQUENCE OF (b)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months							
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
Right Hemisphere Cerebrovascular Accident																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>October 19</u> , 19 <u>79</u> , to <u>Dec</u> , 19 <u>79</u> , that (we) lost saw the deceased alive <u>Dec</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) did (did not) view the body after death.																	
22b. SIGNATURE Robert Brull		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 12/19/79										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/79		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Md.		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE Mary McCreary											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.							
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE		LAST	December 10, 1979									11:00AM			
Ella Elizabeth HAMMOND																			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
August 18, 1898						81						MONTHS DAYS		HOURS MIN.					
85			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington			9a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home			
79			10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY							
35			13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rfd. 6				
70			14. FATHER'S NAME FIRST MIDDLE LAST Elmer Sylvester Renner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Tensman													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 220-09-9495D			16c. INFORMANT Mr. Charles N. Hammond, 313 Reynolds Ave. Hagerstown, Md.			17. ADDRESS 313 Reynolds Ave. Hagerstown, Md.			APPROXIMATE NUMBER BETWEEN ONSET AND DEATH							
No															21740 few hours				
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			4292			CHF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).			DUE TO, OR AS A CONSEQUENCE OF (b),			ASCVD									m				
			DUE TO, OR AS A CONSEQUENCE OF (c),			Gen Arteriosclerosis									yes				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
Anemia																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
99																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 146, 1978, to 12-10, 1979, that (I) (we) last saw the deceased alive on 12-10, 1978, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED 12-12-79				
22b. SIGNATURE Vasant Datta MD						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, MD			22e. ADDRESS 1600 OAK HILL AVE, HAGERSTOWN, MD 21740																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-13-79			23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery			23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.			COUNTY		STATE					
BP																			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Maryland 21713															25a. DATE REC'D. BY REGISTRAR DFC 17 1979		25b. REGISTRAR'S SIGNATURE Bobby L. Johnson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 9 3 1 8 1 5				
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR			
			Charles Edward HARP						December 25, 1979				12:10A M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH March 25, 1900			79			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
Myersville, Md.			U. S. A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington County Hospital			Machine Sup.			Power Co.							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Washington			Hagerstown						1216 Ravenwood Hgts.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
FIRST Charles			MIDDLE W.			LAST Harp			214-10-5532A			Mrs. Frances S. Harp, Hagerstown, Md.			1216 Ravenwood Hgts.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Colon</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (We) attended the deceased from <i>12-23 19 79</i> to <i>12-25 19 79</i> , that (I) (We) last saw the deceased alive on <i>12-24 19 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.															22c. DATE SIGNED <i>12/26/79</i>	
22b. SIGNATURE <i>Eric M. Wagshal</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal, M. D.			22e. ADDRESS 1825 Howell Rd., Hagerstown, Md. 21740													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-28-79			23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery			23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.			ADDRESS Boonsboro, Maryland 21713			25a. DATE REC'D. BY REGISTRAR DEC 28 1979			25b. REGISTRAR'S SIGNATURE <i>Lafayette H. Melvin</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 31816

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
HOWARD			HARTIE			Dec. 10, 1979				1:30	
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		White		Aug. 19, 1901			78		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co.				
Maryland		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		R. D. 5		Watchman			Machine Co.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Washington		Hagerstown				R. D. 5			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST			
Charles				Hartle		Sarah		Martin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH. Enter only one cause per line for 1a), 1b), and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS			
No		180-26-5604		Mrs. S.S. Buhman		Brain death		Hagerstown RD 5 A. Md.			
19. DUE TO, OR AS A CONSEQUENCE OF (b) <i>inhalable smoke to brain</i>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
19b. DUE TO, OR AS A CONSEQUENCE OF (c) <i>inhalable smoke to brain</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from 11-10, 19 79, to 12-10, 19 79, that (I) (we) last saw the deceased alive on 12-9 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert J Ternes MD</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert J Ternes</i>		22e. ADDRESS 648 E Main Waynesboro Penn									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/12/1979		23c. NAME OF CEMETERY OR CREMATORIAL Green Hill Cemetery		23d. LOCATION CITY OR TOWN Waynesboro		COUNTY Franklin		STATE Pa.	
24. FUNERAL DIRECTOR NAME <i>Carolyn Cox</i>		ADDRESS Waynesboro, Penna.		25a. DATE REG'D. BY REGISTRAR DEC 13 1979		25b. REG'D. NAME & SIGNATURE <i>Robert J Ternes</i>					

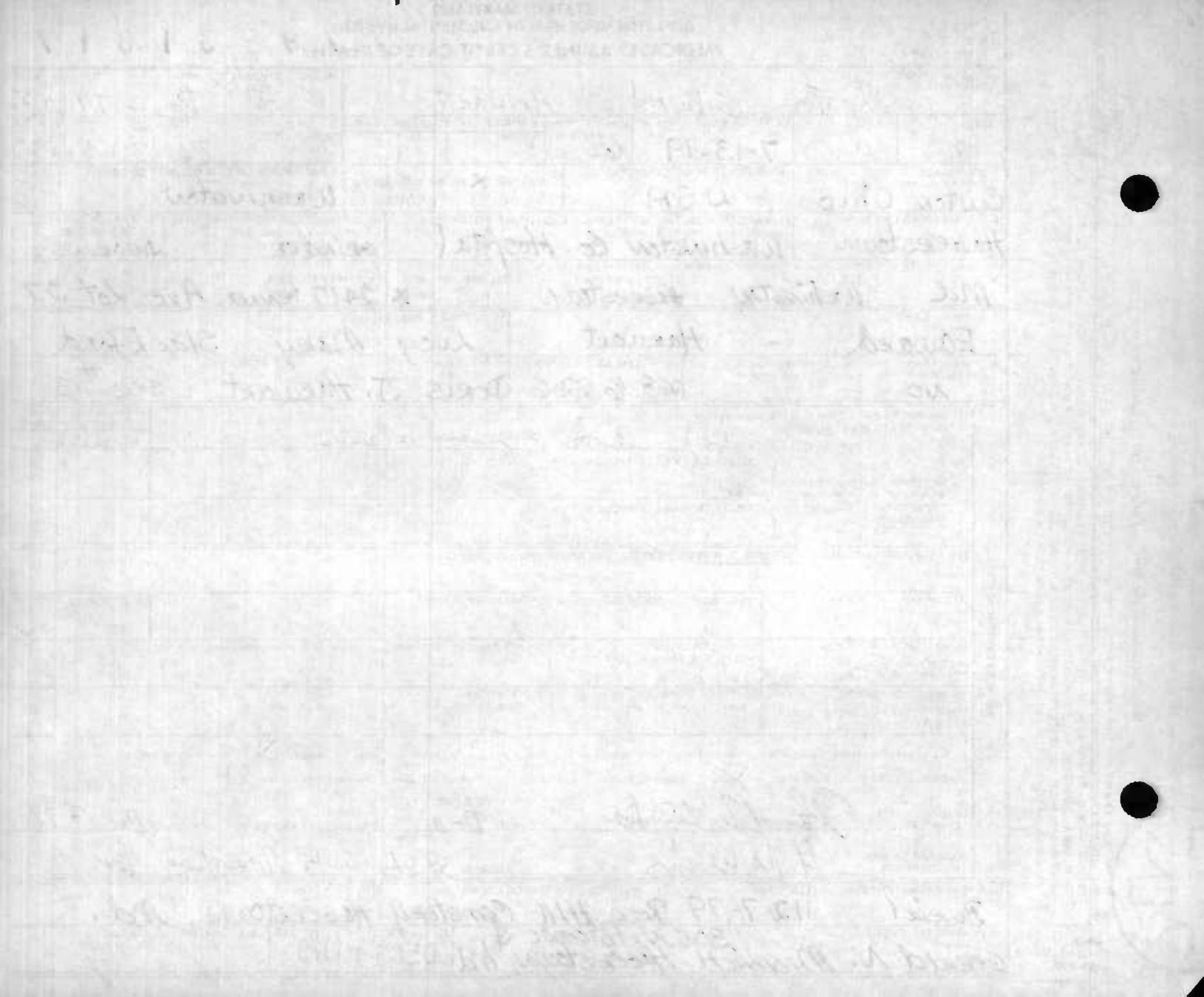
1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31817

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH DAY YEAR	2b. HOUR
Lester Edward Hawwart						<input checked="" type="checkbox"/>	Dec 3 1979	5:50 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD	
M	W	7-13-19	60 yrs.				Dec 3 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Canton, Ohio		USA					Washington	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington Co. Hospital					Grinder Bearings	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	
Md		Washington		Hagerstown			2417 Penna. Ave Lot 27	
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		ADDRESS		
Edward		- Hawwart		Lucy Mary Slackford		see #13		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		268 16 2206		Doris J. Hawwart		sudden		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarcti</u> DUE TO, OR AS A CONSEQUENCE OF 410- Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		H. M. Weeks			TITLE (SPECIFY) M.D. Dep		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS, 586 Northern Av Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		
Burial		12-7-79		Rose Hill Cemetery		Hagerstown, Md.		
24. FUNERAL DIRECTOR NAME		305 N. Potomac St		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Gerald N. Minnich		Hagerstown, Md.		DEC 11 1979		Gerald N. Minnich		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7	9	3	1	8	1	8								
CERTIFICATE OF DEATH										REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
Emma Hazel Hastings									H.			12-8-79			3:15									
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH May			YEAR 93			6. AGE (IN YEARS LAST BIRTHDAY) 84			YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Waynesboro, Pa			7b. CITIZEN OF WHAT COUNTRY? USA			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County			MD.									
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cotton Villa Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RN			12b. KIND OF BUSINESS OR INDUSTRY nursing															
13a. STATE Md.			13b. COUNTY Wash.			13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 2 Box 143, Boonsboro, Md.												
14. FATHER'S NAME FIRST James			MIDDLE Evily			15. MOTHER'S MAIDEN NAME FIRST Emma			LAST Hollinger															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. No			17. INFORMANT Husband			ADDRESS 197-824															
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c)			Calvin Hastings, Rt. Box 143, Boonsboro, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome																								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>11-20-79</u> to <u>12-8-79</u> , that (I) (we) last saw the deceased alive on <u>11-20-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE Vasant Datta			MD			DEGREE			ATTENDING PHYSICIAN Vasant Datta			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-10-79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, MD			22e. ADDRESS 1600 OAK HILL AVE, HAGERSTOWN, MD 21740																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-11-79			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.			COUNTY		STATE										
24. FUNERAL DIRECTOR A.K. Coffman Funeral Home, Inc., Hagerstown, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 13 1979			25b. REGISTRAR'S SIGNATURE John Melby															

Wolfgang Leibl

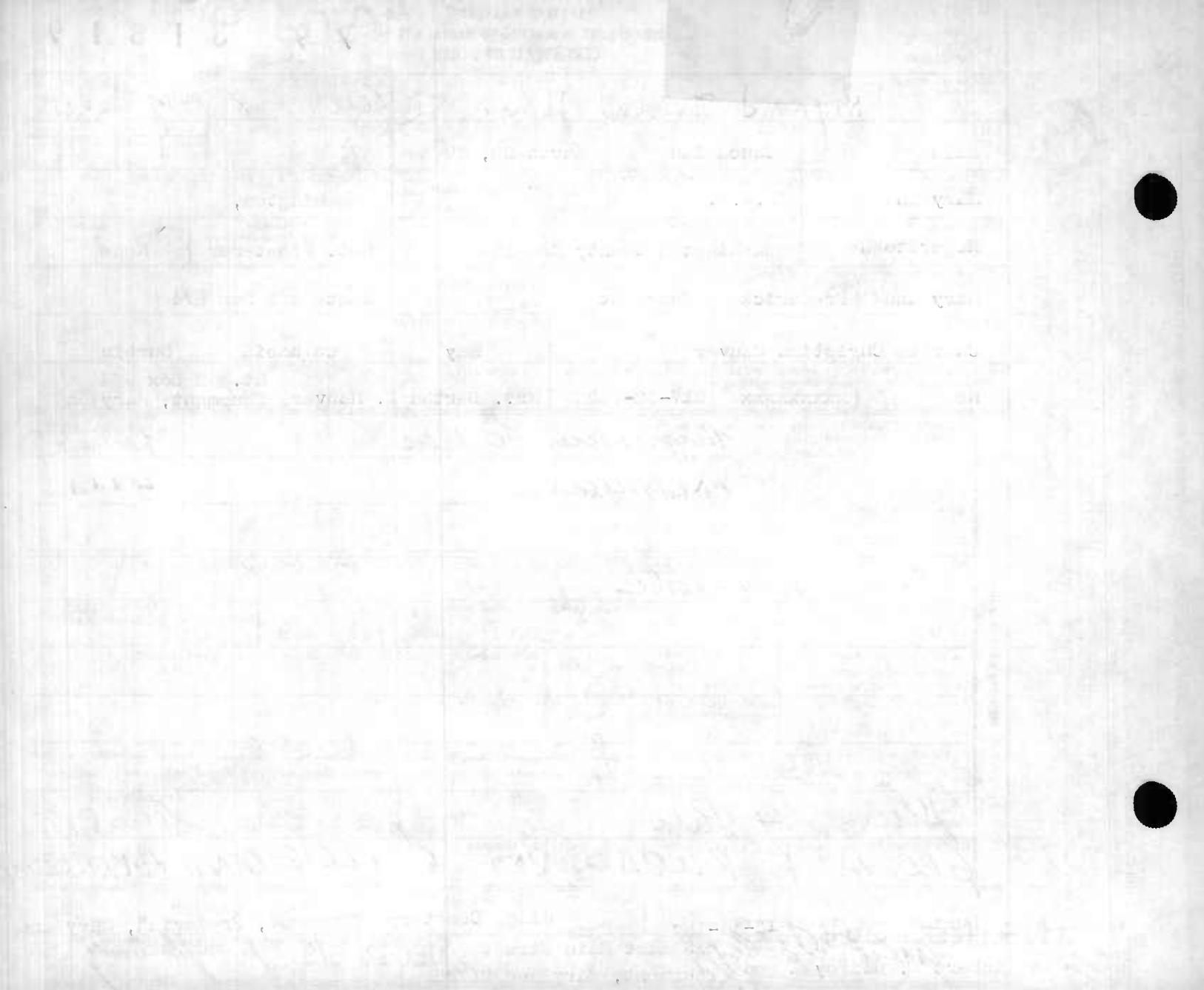


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	1	9		
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Raymond Christian Hauver SR												Dec. 8, 1979						2:35 AM		
3. SEX			4 RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS			
Male			Caucasian			MONTH March 23, 1904			DAY			75			YRS.	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			U.S.A.			<input checked="" type="checkbox"/>			<input type="checkbox"/>			Washington,								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown			Washington County Hospital			Ret. Plasterer			None											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Frederick			Thurmont			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route # 2 Box 674								
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
Charles Christian Hauver												May								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No			XXXXXXXXXX			217-12-1422			Mrs. Bertha L. Hauver			Rt. # 2 Box 674			years					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
492- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												years								
(b) <u>hypoxysena</u>																				
(c) <u></u>																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>car plegnale</u>																				
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									<input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 11, 1979</u> to <u>Dec. 8, 1979</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED <u>Dec. 8, 1979</u>								
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GLORIA F. RURA</u>												23b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23c. ADDRESS 382 S. CLEVELAND HAGERSTOWN																				
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23e. DATE			23f. NAME OF CEMETERY OR CREMATORIAL Ridge Cemetery			23g. LOCATION CITY OR TOWN			23h. COUNTY			23i. STATE					
12-11-1979			Blue						Thurmont, Frederick			Maryland								
24. FUNERAL DIRECTOR NAME Robert E. Dailey & Son			ADDRESS 615 East Main Street			25. DATE REC'D. BY REGISTRAR DEC 19 1979			25. REGISTRAR'S SIGNATURE <u>Robert E. Dailey</u>											
26. ADDRESS Thurmont, Maryland 21788																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	2	0
1 - STATE REGISTRAR												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
William Russell Howard Sr.												12-28-79					10:00 AM	
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH January			YEAR 1893			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington		YRS.		MONTHS DAYS HOURS MIN		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Bank									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 824 The Terrace									
14. FATHER'S NAME Albert A. Howard						15. MOTHER'S MAIDEN NAME Bertha Hoover												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW I			17. INFORMANT Mrs. Mildred C. Howard, Hagerstown, Md.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			acute myocardial infarction			11 Dec 79			DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic cardiac disease			years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive cardiovascular disease																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN									
22a. I certify that (I) (this hospital) attended the deceased from below. The deceased died on <u>28 Dec 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.						19			19									
22b. SIGNATURE Richard G. Binfur						22c. DATE SIGNED 18 Dec 79												
22d. PHYSICIAN'S NAME, CITY OR STATE Binfur						22e. ADDRESS Hagerstown, Md.												
23a. BURIAL, CREMATION, REMOVAL ESPECIALLY burial			23b. DATE Dec. 31, 1979			23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			23d. LOCATION CITY, STATE Hagerstown, Wash., Maryland									
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR JAN 4 1980			25b. REGISTRAR'S SIGNATURE Loyalty McAlister									

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

31821
REG. NO.

1 - STATE REGISTRAR		9																					
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES			MIDDLE EUGENE		LAST HUBBARD			2a. DATE KNOWN OF DEATH													
2. SEX		3. RACE		4. DATE OF BIRTH MONTH DAY YEAR		5. AGE (IN YEARS LAST BIRTHDAY)		6. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		8. 2c. DATE PRONOUNCED DEAD											
Male		White		May 11 1959		20 yrs.						Month Day Year											
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NAME, ADDRESS, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. STATE		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S M AIDEN NAME FIRST MIDDLE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gun shot under chin Thru Head</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>E 955 Suicide</i> DUE TO, OR AS A CONSEQUENCE OF (c)		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Hagerstown		Washington Co. Gen. Hospital		Mechanic		Maryland		Charles W. Hubbard		Helen Louise Fowler Wetzel		No No		21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 4:30 P.M. Dec 15 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>self inflicted</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>woods</i>		21f. LOCATION STREET <i>nr. Harper's Ferry</i>		CITY OR TOWN <i>WV</i>		COUNTY <i>WV</i>		STATE <i>MD</i>													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) <i>R. G. Weeks M.D.</i>		22c. MEDICAL EXAMINER <i>R. G. Weeks</i>		22d. DATE SIGNED <i>Dec 15 79</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/1979		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Winters Cemetery Union Bridge, Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Carroll County, Maryland</i>																	
24. FUNERAL DIRECTOR <i>R. G. Weeks</i>		25a. ADDRESS <i>Union Bridge, Md.</i>		25b. DATE REC'D. BY REGISTRAR DEC 19 1979		25c. REGISTRAR'S SIGNATURE <i>Prophybelinsky</i>																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. PAGE SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE DEATH CERTIFICATE, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 7/77



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7931822				
1. FOR - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 12/16/79 16									2b. HOUR 4:30 P.M.				
1. DECEASED NAME (TYPE OR PRINT) HARRY WILLIAM JULIAN III			3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR SEPT. 3 1935			6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.							
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTERN MARYLAND HOSPITAL CENTER			12a. USUAL OCCUPATION RESTAURANT OWNER			12b. KIND OF BUSINESS OR INDUSTRY SELF EMPL.							
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN GAITHERSBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 10613 SENECA RIDGE DR.				
14. FATHER'S NAME FIRST HARRY MIDDLE W. LAST JULIAN			15. MOTHER'S MAIDEN NAME FIRST MABLE MIDDLE LAST BOREN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 552-46-8176			17. INFORMANT BARBARA L. JULIAN (SAME AS 13e)			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1o) ① Bronchopneumonia. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			DUE TO, OR AS A CONSEQUENCE OF (b) ② Renal failure due to age 78			(c) #1 48 hrs										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1o																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE							
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g. DATE SIGNED 12/16/79										
22a. I certify that (1) (this hospital) attended the deceased on 12/16/79, 19, to 12/16/79, 19, that (1) (we) lost saw the deceased alive on above, (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 12-16-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. milania M.D.			22e. ADDRESS 1500 Penna Ave, Hagerstown, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 12-18-79			23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN ALEXANDRIA FAIRFAX VA.			COUNTY FAIRFAX				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES P/A			25a. DATE REC'D. BY REGISTRAR DEC 20 1979			25b. REGISTRAR'S SIGNATURE Robert A. Pumphy										
ROCKVILLE MARYLAND																

100

25/10/2011

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 9 3 1 8 2 3					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED		2b. MONTH YEAR	2c. HOUR 30 10AM		
Beatrice			Anne			Kale						<input checked="" type="checkbox"/> Dec. 4 1979		9	10AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2d. DATE PRONOUNCED DEAD		2e. MONTH DAY YEAR		2f. HOUR 30 10AM	
Female		White		Jan. 15, 1943		36 yrs.		MONTHS		DAYS		HOURS		Dec. 4 1979		Dec. 4 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. MARRIED NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Baltimore, MD		USA						Washington									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital						Secretary			industry					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland			Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1103 Virginia Avenue								
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
Robert			Albert		Voeikel		Anna		Emilia		Litke						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS					
no			219-40-8691						F. Steven Kale see #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 881 Cerebral contusion as a result of DUE TO, OR AS A CONSEQUENCE OF fall from a ladder												days					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21e. LOCATION STREET CITY OR TOWN COUNTY				
			2 P.M. Nov. 27 1979			Fell off ladder while cleaning windows			home				1103 Virginia Avenue Hagers. Wash. MD				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy										DATE SIGNED Dec 7, 79					
EXAMINER'S NAME Howard N. Weeks, M.D.P.A. ADDRESS 580 Northern Ave. Hagers. MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			12-7-79			Cedar Lawn Memorial			Hagerstown			Wash. Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Gerald N. Minnich			305 N. Pot. St. Hagers. MD			Dec 28 1979			McCreedy								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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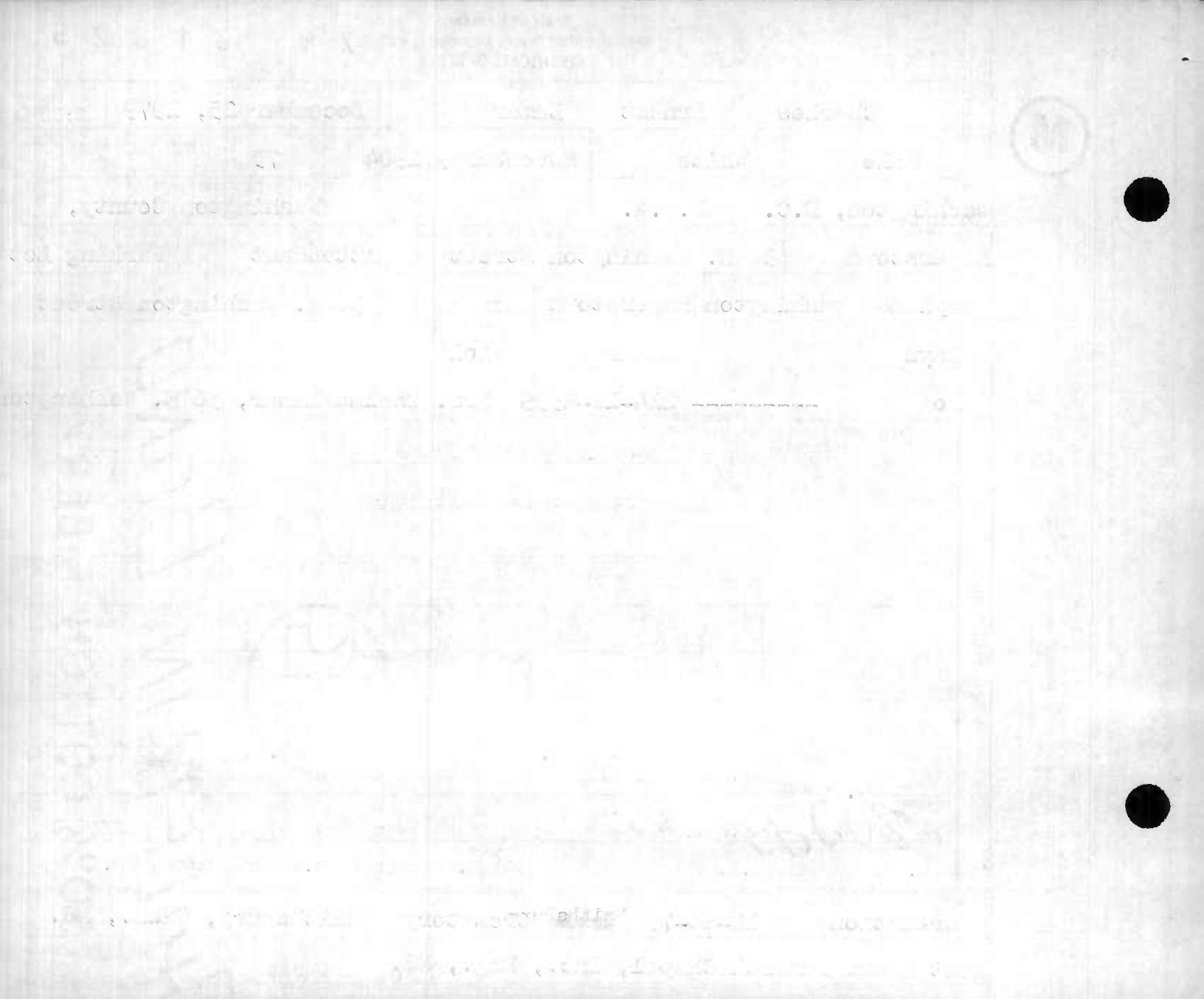
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			James webster Kesselring			12/14/79 14 1979			6:45 P.M.					
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR December 4, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 65					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Railroad					
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Williamsport			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13e. STREET ADDRESS 101 Sheridan Drive, Williamsport, Md.			13f. MOTHER'S MAIDEN NAME Hazel Brewer											
14. FATHER'S NAME FIRST Arthur			MIDDLE F.			LAST Kesselring			15. ADDRESS ADDRESS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. -----			17. INFORMANT James A. Kesselring, Route 1 Fairplay, Maryland 21733			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4275 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c)												DUE TO, OR AS A CONSEQUENCE OF (b) ① Cardiac arrest. Sudden DUE TO, OR AS A CONSEQUENCE OF (c) ② History of Hypoxic Encephalopathy. Oct 25, 1979 ③ Cardi		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12/14/79 , 19 79 , to 12/14/79 , 19 79 , that (I) (we) last saw the deceased alive on 12/14/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED		
22b. SIGNATURE Julianina M. D.			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julianina M. D.			22e. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-18-79			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery Hagerstown, Wash., Md.			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag.,			ADDRESS Rest Haven Funeral Chapel, Inc., Hag.,			25a. DATE REC'D. BY REGISTRAR DEC 20 1979			25b. REGISTRAR'S SIGNATURE harry m. murray					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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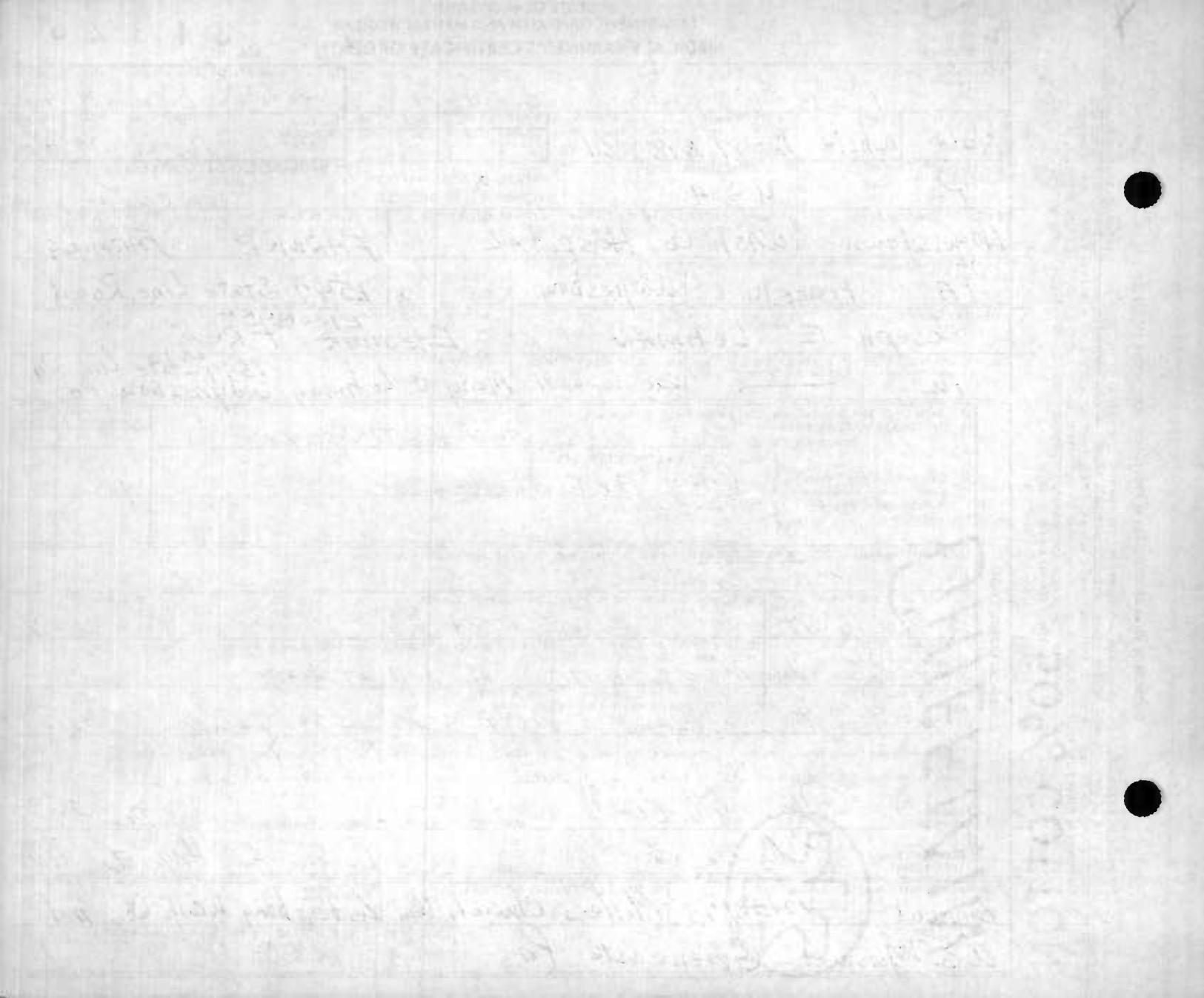
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	2	5
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Charles			Ernest	Lamar		December 25, 1979						12:30 P						
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male			White		November 9, 1904		75			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Washington, D.C.			U.S.A.							Washington County, MD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown			36 E. Washington Street		Attendant					Parking Lot								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			36 E. Washington Street								
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST					MIDDLE	LAST							
Hays				Lamar	Viola													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No			214-18-2599		Mrs. Thelma Lamar, 36 E. Washington					1 week								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY:																		
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>																		
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u>																		
} DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE						
22a. I certify that (I) <u>W. T. Layman</u> attended the deceased from <u>Dec. 18, 1979</u> , to <u>Dec. 25, 1979</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>Dec. 18, 1979</u> , and that in (my) <u>xx</u> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did <u>xx</u> view the body after death.												22b. DATE SIGNED <u>12/26/79</u>						
22c. SIGNATURE <u>W. T. Layman, M.D.</u>			22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>												
22e. PHYSICIAN'S NAME (IF DIFFERENT) W. T. Layman, M.D.			22f. ADDRESS 301 E. Antietam St., Hagerstown, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION CITY OR TOWN Smithsburg, Wash., Md.			23e. COUNTY Wash.			23f. STATE Md.					
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hagerstown, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 31 1979			25b. REGISTRAR'S SIGNATURE <u>John W. Layman</u>									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												31826	
												REG. NO.	
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE KNOWN OF DEATH ESTI- MATED			2b. HOUR MONTH DAY YEAR	
Amos			FREY			Lehman			<input checked="" type="checkbox"/> Dec 25 1979			4 PM	
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male		White		Dec. 17, 1898		81 yrs.						Dec 25 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pa.		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Washington MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Wash. Co. Hospital			FARMER			FARMING				
13a. STATE PA.			13b. COUNTY Franklin			13c. CITY OR TOWN Waynesboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1597 State Line Road	
14. FATHER'S NAME Joseph E. Lehman						15. MOTHER'S MAIDEN NAME Eleanor Frey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-30-8881			17. INFORMANT Mary C. Lehman			ADDRESS 1597 State Line Rd. Waynesboro, Pa.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) <u>congestive heart disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YES	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). RT hip fracture													
19a. DATE OF OPERATION Dec 16 79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured RT hip			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 PM Dec 15 1979			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) RT. fall AT home							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 1597 STATE LINE RD CITY OR TOWN Waynesboro COUNTY Penns							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> M.D.			and in my opinion							
ACTUAL SIGNATURE H. N. Weeks			TITLE (SPECIFY) M.D.			DATE SIGNED Dec 25, 79							
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS 580 Northern Av Hagerstown, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/28/79			23c. NAME OF CEMETERY OR CREMATORIAL Miller's Church Cem.			23d. LOCATION CITY OR TOWN Leitersburg, Wash. Co., Md.				
24. FUNERAL DIRECTOR NAME A. C. Minich - Greencastle, Pa.						25a. DATE REC'D. BY REGISTRAR DEC 28 1979			25b. REGISTRAR'S SIGNATURE H. N. Weeks				



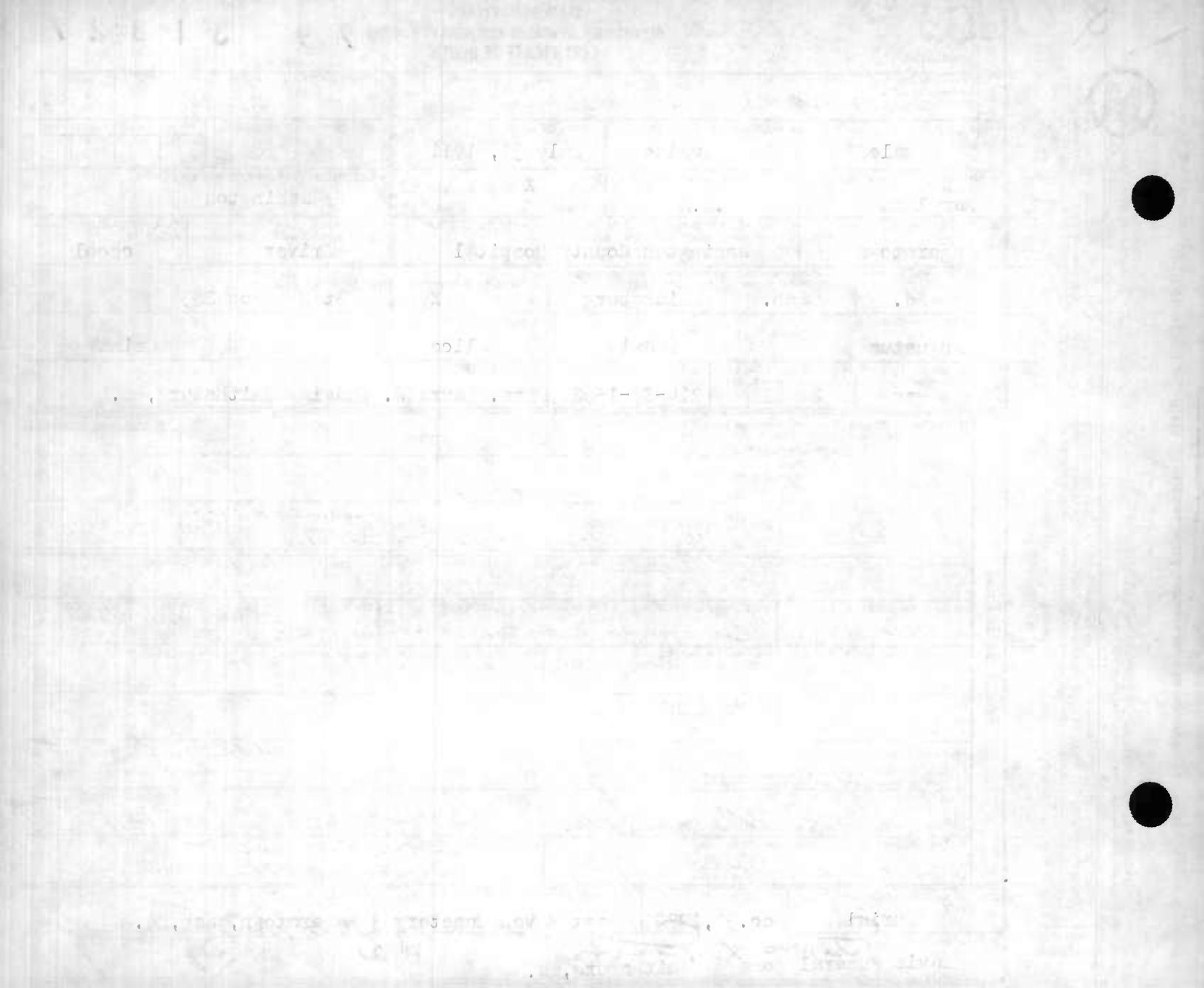
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 2 7						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
FREDERIC			Augustas			Ludwig						12 28 79					12:23 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH						6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
male		white		MONTH July 31, 1911 DAY YEAR						68		MONTHS		DAYS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED			NEVER MARRIED			9 BALTIMORE CITY OR COUNTY OF DEATH		YRS.						
Maryland		U.S.A.		<input checked="" type="checkbox"/>			<input type="checkbox"/>			Washington								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Washington County Hospital		Driver			School											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13a. STREET ADDRESS								
Md.		Wash.		Smithsburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt 2 Box 283								
14 FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST						
Augustus				Ludwig			Alice					Grimm						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			17. ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
yes		WW II		214-09-1562			Mrs. Laura J. Ludwig			Smithsburg, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												CARDIAC ARREST						
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) HYPER CALCEMIA						
DUE TO, OR AS A CONSEQUENCE OF (b) HYPER CALCEMIA												CARCINOMA RIGHT LUNG						
DUE TO, OR AS A CONSEQUENCE OF (c) POORLY DIFFERENTIATED SQUAMOUS CELL												LUNG + 13 mos						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
11/10/78		CARCINOMA RIGHT LUNG		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from NOV 19 78, to DEC 19 79, that (II) (we) last saw the deceased alive on 27 DEC 19 79, and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (II) (we) did (did not) view the body after death.																		
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
John R. Marsh, M.D.											12/25/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN					
John R. MARSH, M.D.		239 N. POTOMAC ST HAGERSTOWN, MD. 21740		Burial			Dec. 31, 1979			Rest Haven Cemetery			Hagerstown, Wash. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Dennis L. Davis Funeral Home		Smithsburg, Md.		JAN 2 1980														

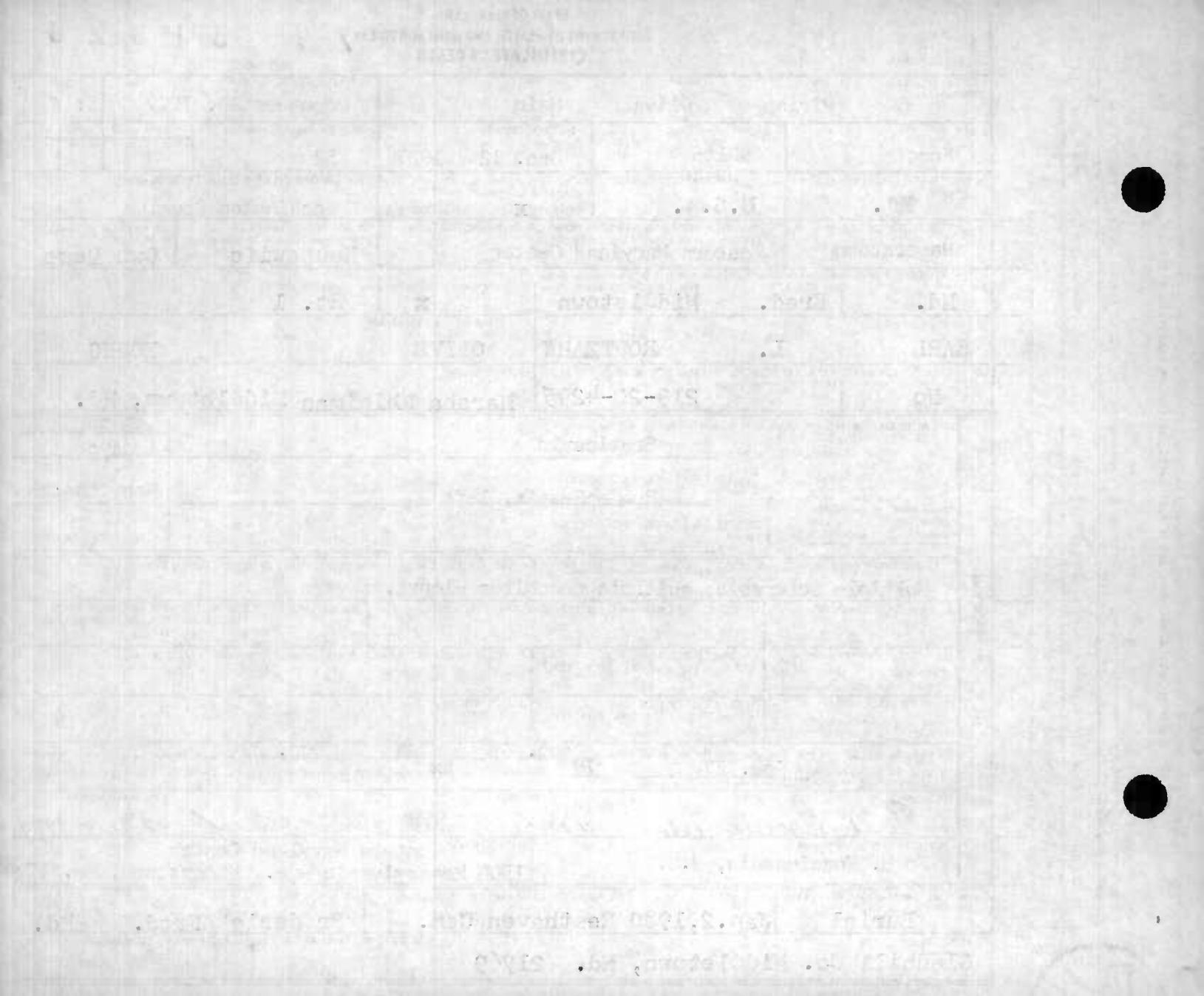


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1 - FOR STATE REGISTRAR			7 9 3 1 8 2 8 REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Miriam Olive Main									December 29, 1979			5:16 P M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Dec. 12 1927			52			MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Washington County MD.				
Md.		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Western Maryland Center		Housewife			Own Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.		Fred.		Middletown						Rt. 1				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
EARL L. RÖUTZAHN		OLIVE YOUNG												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		219-20-4295		Marsha Rhiniman			Middletown, Md.			days				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
Septicemia														
5908 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) Pyonephrosis, left														
Many months														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Multiple sclerosis; multiple decubitus ulcers, severe														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 6, 1964, to Dec. 29, 1979, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Dec. 29, 1979, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.														
22b. SIGNATURE Fe U. Porciuncula M.D.					DEGREE						22c. DATE SIGNED Dec. 31, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M.D.		22e. ADDRESS Western Maryland Center 1500 Pennsylvania Ave., Hagerstown, Md. 21740												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Cem.			23d. LOCATION CITY OR TOWN Frederick			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Gladhill Co. Middletown, Md.		ADDRESS 21769		25a. DATE REC'D. BY REGISTRAR JAN 4 1980			25b. REGISTRAR'S SIGNATURE Patsy McCready							
BP														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 8 2 9					
1. DECEASED NAME (TYPE OR PRINT)				FIRST			MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
John				Robert			Malcolm					11		25	79	9:30 P.M.			
3. SEX MALE				4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR		12-29-1898			6. AGE (IN YEARS LAST BIRTHDAY)		80 yrs.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED XX		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON		MD.		
10. CITY OR TOWN OF DEATH HAGERSTOWN				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			FOREMAN		AGRICULTURE					
13a. STATE MARYLAND				13b. COUNTY WASHINGTON			13c. CITY OR TOWN BIG POOL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ROUTE 3 BOX 94							
14. FATHER'S NAME FIRST JACOB				MIDDLE nmi			LAST MALCOLM		15. MOTHER'S MAIDEN NAME FIRST AMANDA			MIDDLE nmi		LAST COX					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 217 30 5431			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. 5 yrs. cert.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 days							
									(c) Hypertensive vascular disease DUE TO, OR AS A CONSEQUENCE OF 19 years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Aneurysm abdominal aorta, pulmonary emphysema. Peripheral vascular disease																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the physician) attended the deceased from saw the deceased alive on above, (I) (the physician) did not view the body after death.				11/25 1979			10/29/ 1979 to 11/25 1979												
22b. SIGNATURE W. T. Layman, M.D.				22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 12/5/79									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) W. T. Layman, M.D.				22g. ADDRESS 301 E. Antietam St., Hagerstown, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 11/28/1979			23c. NAME OF CEMETERY OR CREMATORIAL WOODROW CEMETERY			23d. LOCATION CITY OR TOWN			COUNTY STATE						
24. FUNERAL DIRECTOR Grove Funeral Home, Hancock, Md.				25a. DATE REC'D. BY REGISTRAR DEC 12 1979			25b. REGISTRAR'S SIGNATURE Morgan, West Va.												
BP																			
DHMH - 16 50M 1/76 (VR A 15 (4))																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 3 1 8 3 0			
1 - STATE REGISTRAR Frank Porter Matthews CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	
FRANK PORTER MATTHEWS						12 21 79			18A			18A M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH DAY YEAR			90			MONTHS	DAYS	HOURS	MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.					Washington County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Washington County Hospital					Railroad						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a STREET ADDRESS			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			25 South Locust Street				
14. FATHER'S NAME FIRST Harry		MIDDLE B.		LAST Matthews		15. MOTHER'S MAIDEN NAME FIRST Katie			MIDDLE		LAST Porter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			25 South Locust St. Hagerstown, Md.			
No		717-07-9369		Mrs Milbrey S. Matthews									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Pneumonia.</i>										1 week			
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>lumbar stenosis in only functioning kidney (right)</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12-21-79			
22b. SIGNATURE <i>Charles C. Spencer MD.</i>		22c. DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHARLES C. SPENCER</i>		22e. ADDRESS 1189 HENLEY AVE HAGERSTOWN											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-24-79		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.		ADDRESS 1189 HENLEY AVE HAGERSTOWN		25a. DATE REC'D. BY REG. STAR DEC 27 1979			25b. REGISTRAR'S SIGNATURE <i>Frank Porter Matthews</i>						

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1970-00000000-00000000

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS.

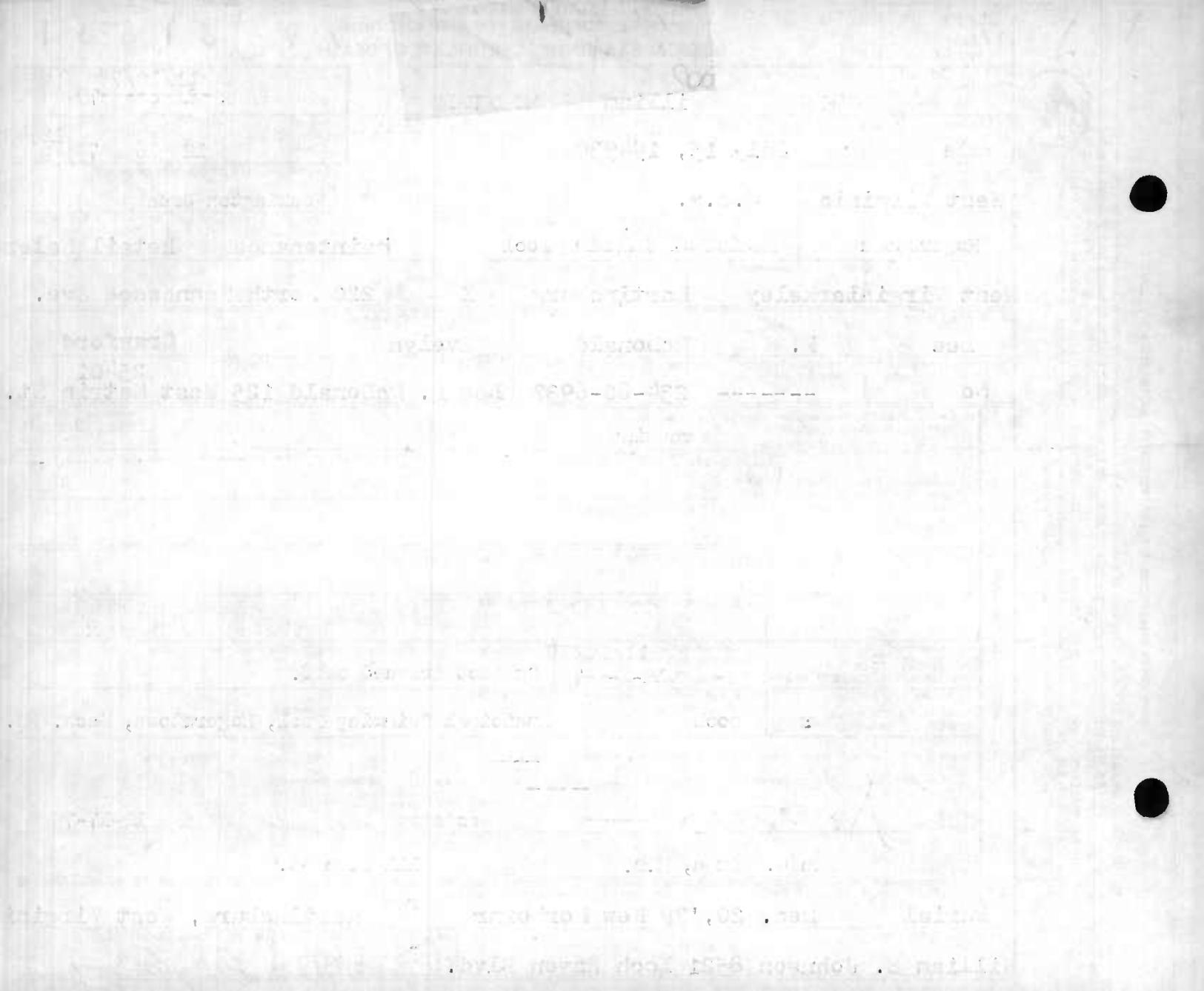
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

Items 2a & 21b G539 1/21/80 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31831

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH 1/19/79	DAY 79	YEAR 79	2b. HOUR 12:40 p.m.			
JAMES William MC DONALD						<input checked="" type="checkbox"/>	12-8-79	19					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. HOURS	10. MIN		2d. DATE PRONOUNCED DEAD	MONTH 12	DAY 16	YEAR 1979	2d. HOUR 12:40 p.m.
male	white	July 15, 1949 30 yrs.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. MARRIED NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia		U.s.a.			<input checked="" type="checkbox"/>		<input type="checkbox"/>		Washington County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Municipal Swimming Pool			Maintenance			Retail Sales					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE West Virginia		13b. COUNTY Barkeley		13c. CITY OR TOWN Martinsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 220 North Tennessee Ave.					
14. FATHER'S NAME FIRST Lee		MIDDLE P.		LAST McDonald		15. MOTHER'S MAIDEN NAME FIRST Evelyn		LAST Crawford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		25401					
No		234-80-6937		Lee P. McDonald		125 West Matrin St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. - 12-8-79			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject drowned self.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) pool			21f. LOCATION STREET Municipal Swimming Pool, Hagerstown, Wash. Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER													
ACTUAL SIGNATURE													
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Dec. 20, '79			23c. NAME OF CEMETERY OR CREMATORIAL New Norborne			23d. LOCATION CITY OR TOWN Martinsburg, West Virginia		STATE County			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
William E. Johnson 8521 Loch Raven Blvd.					DEC 19 1979			<i>Brody</i>					



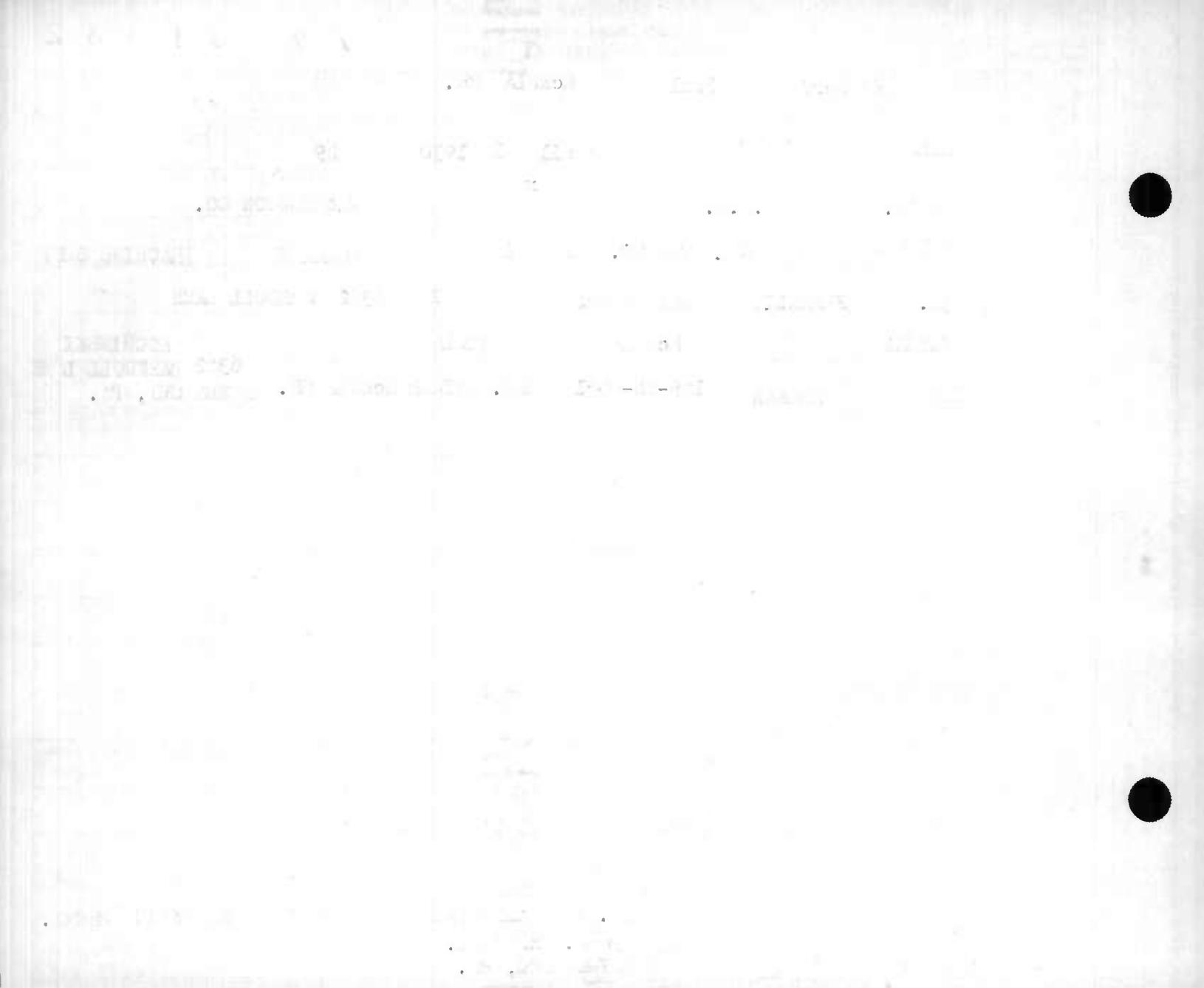
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						7	9	3	1	8	3	2	
						REG. NO. 7931832							
1. DECEASED NAME (TYPE OR PRINT)		Richard RICHARDSON		Paul PAUL		McKULA SR.		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
3. SEX		MALE		WHITE		McKULA		12		18	79	5 ¹⁰	AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. DATE OF BIRTH		7d. AGE (IN YEARS LAST BIRTHDAY)		6. AGE (IN YEARS LAST BIRTHDAY)		6f. UNDER 1 YEAR		6g. UNDER 24 HRS	
PENNA.		U.S.A.		MONTH April 8 1930		49		YRS.		MONTHS		DAYS	
7e. CITY OR TOWN OF DEATH		7f. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		7g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7h. BALTIMORE CITY OR COUNTY OF DEATH							
HAZERSTOWN		WASHINGTON CO. HOSPITAL		WASHINGTON CO.									
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
11a. STATE PENNA.		11b. COUNTY FRANKLIN		11c. CITY OR TOWN WAYNESBORO		13a. STREET ADDRESS 6362 BARKDOLL LANE		12b. KIND OF BUSINESS OR INDUSTRY MACHINE SHOP					
14. FATHER'S NAME STEPHEN		MIDDLE		15. MOTHER'S MAIDEN NAME VIOLA		13b. ADDRESS 6362 BARKDOLL LANE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. YES KOREAN 169-24-8061		17. INFORMANT MRS. ESTHER McKULA SR.		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH PA. WAYNESBORO, PA.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						END STAGE REFLX DISEASE							
5503 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) DIABETIC NEUROPATHY							
						DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 ALNUTRITION													
19a. DATE OF OPERATION 12/15-11/6		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10. 6. 1978 to 12. 18. 1978, that (I) (we) last saw the deceased alive on 12. 18. 1978 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) did not view the body after death.													
22b. SIGNATURE		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO R. ZA		22f. ADDRESS 600 Lakeview Dr. Quincy IL 60451											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM MT. ZION CEMETERY		23d. LOCATION CITY OR TOWN QUINCY		23e. COUNTY FRANKLIN		23f. STATE PENNA.			
24. FUNERAL DIRECTOR NAME David J. Gove		ADDRESS 50 S. BROAD ST. WAYNESBORO, PA.		25a. DATE REC'D. BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE David J. Gove							

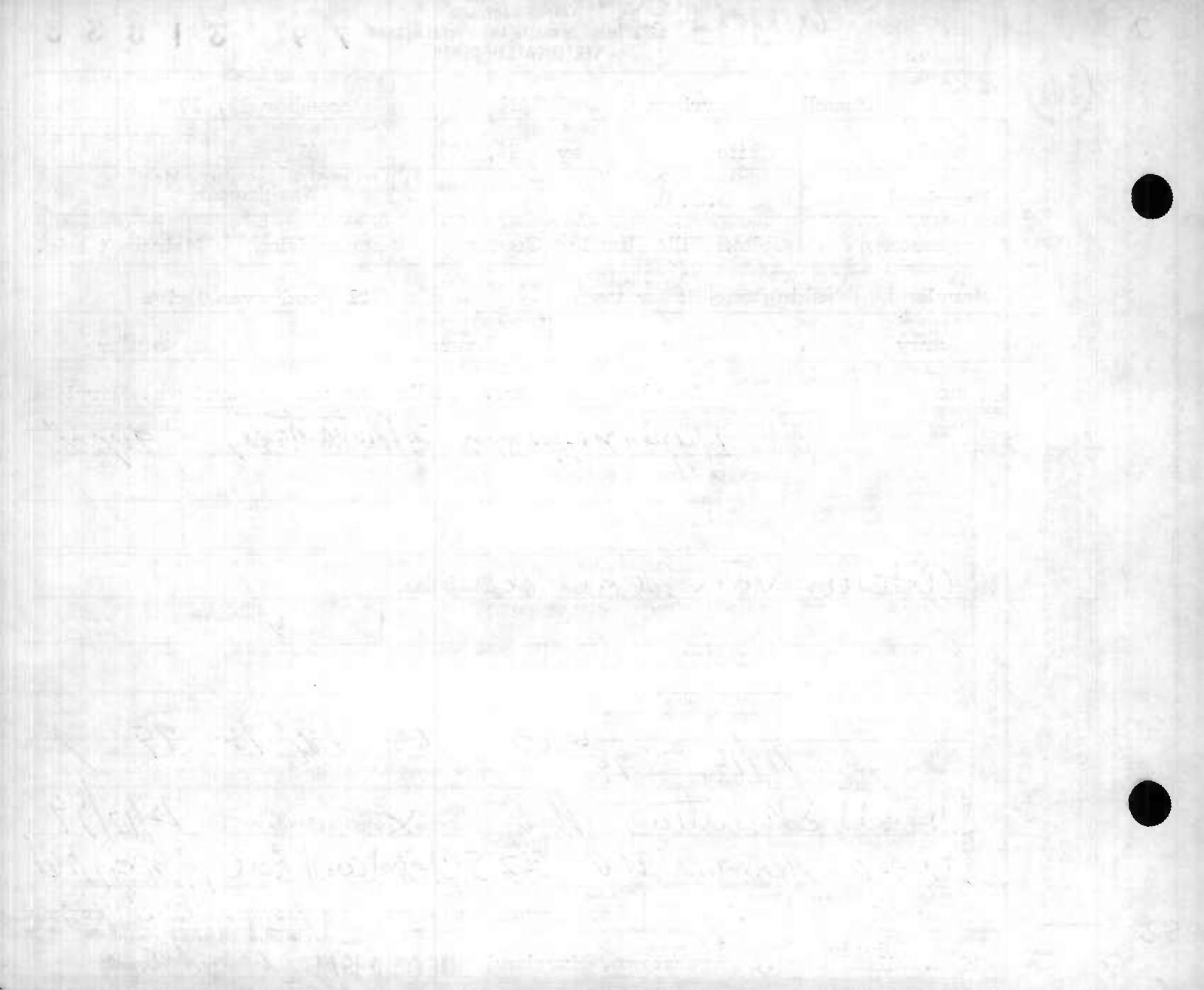


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please return it to us as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	3	3
												REG. NO.						
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
			Russell Harrison MORGAN						December 15, 1979									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White			MONTH DAY YEAR May 26, 1912			67			MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown			Colton Villa Nursing Center			Supervision			aircraft mfg.									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland			Washington			Hagerstown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			201 Woodhaven Drive						
14. FATHER'S NAME			MIDDLE			15. MOTHER'S MAIDEN NAME						LAST						
FIRST Harry			MIDDLE H.			LAST Morgan			FIRST Laura			MIDDLE			LAST Butler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN DEATH AND MILE									
no			705-10-5944			Mrs. Estelle Morgan, Hagerstown, Maryland			9922									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Hyper reppress & Metadex						
1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b)						
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Atherosclerotic heart disease																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 4413 CITY OR TOWN 65 STATE 12/15/79 COUNTY 29												
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/14/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.																		
23. SIGNATURE Donald E. Martin, MD												22c. DATE SIGNED 12/12/79						
24. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
DONALD E. MARTIN, MD			3635 Cleveland Ave., Hagerstown, MD															
23e. BURIAL, CREMATION, REMOVAL (SPECIFY)			23f. DATE			23g. NAME OF CEMETERY OR CREMATORIAL			23h. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Burial			Dec. 19, 1979			Rest Haven Cemetery			Wash., Maryland			DEC 19 1979			Lester McBrady			
24. FUNERAL DIRECTOR NAME			415 E. Wilson Blvd., Hagerstown, Maryland															
Minnich Funeral Home																		

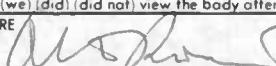
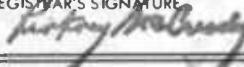


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 8 3 4				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Vivian			Beatrice			MULLENDORE			December 6, 1979			3:00 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White			Month Day Year May 19, 1927			52			MONTHS DAYS		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Hagerstown, Md.			U. S. A.						Washington			YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital			None								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Washington			Smithsburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Box 48		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
FIRST Edgar MIDDLE D. LAST Mullendore			FIRST Nellie MIDDLE Lucille LAST Smith											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Rfd. 2		
No			214-36-03380			Mr. Edgar D. Mullendore, Boonsboro, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) 5698 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any										DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIC SHOCK				
DUE TO, OR AS A CONSEQUENCE OF (c) SEPTICENIA - PERITONITIS										DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATION of SIGMOID GLASS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20, PART 1 OR PART 2)								
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12-4, 1979, to 12-6, 1979, that (I) (we) last saw the deceased alive on 12-6, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE 										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZA										22e. ADDRESS 100-LONG MEADOW DRIVE HAG. RD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)			23b. DATE 12-10-79			23c. NAME OF CEMETERY OR CREMATORIAL Rohrersville Cemetery			23d. LOCATION CITY OR TOWN Rohrersville, Wash. Co., Md.			STATE		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713										25a. DATE REC'D. BY REGISTRAR DEC 12 1979				
										25b. REGISTRAR'S SIGNATURE 				

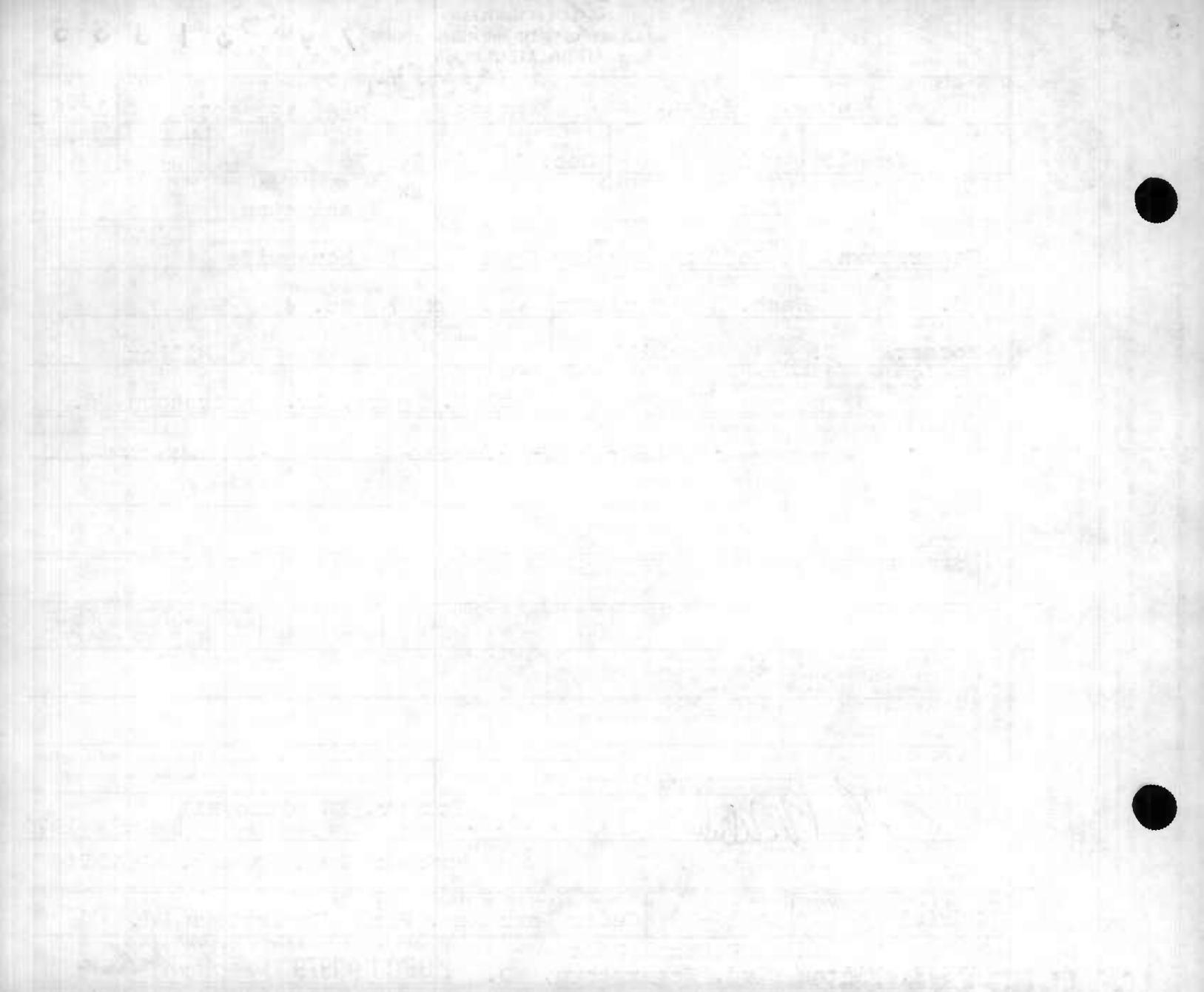
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-900-3850.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 3 1 8 3 5							
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Thelma Helena MYERS								Dec. 13, 1979				150 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
female		white		Dec. 18, 1902				76 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		USA						Washington							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Coffman Nursing Home				housewife									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								13a. STATE 13b. COUNTY 13c. CITY OR TOWN							
Md.								Wash. Hagerstown							
14. FATHER'S NAME FIRST MIDDLE LAST								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Rosser C. Crabill								Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
no				219-36-2600				Earl M. Myers, Sr. Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Coronary Heart Disease															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not view the body after death.															
22b. SIGNATURE DEGREE For Dr. EW Ditto, III M.D.P.A. ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>															
22c. DATE SIGNED Dec. 14, 1979															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
Howard N. Weeks, M.D.P.A.				580 Northern Ave. Hagers. MD 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN COUNTY STATE			
burial				12-15-79				Cedar Lawn Mem. Park				Hagerstown, Md.			
24. FUNERAL DIRECTOR NAME Minnich Funeral Home ADDRESS 415 E. Wilson Blvd. Hagerstown, MD.								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
								DEC 19 1979				Loyalty McBrady			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31836											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED		2b. MONTH DAY YEAR	2d. HOUR								
WALTER			Gardner			Nelson			<input checked="" type="checkbox"/>		Dec 17 1979	5:30 P.M.											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR								
M		W		May 9, 1920			59 yrs.						Dec 17 1979		6:55 P.M.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH											
Pa.			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>			WASHINGTON MD.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown			Washington County Hospital									Finisher		Manufacturing									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		Route 1, Box 261	
Maryland		Washington		Dargan								Harpers Ferry, W V 25425											
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST											
William			James			Nelson			Ruth			Gardner											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT			16d. ADDRESS			Route 1, Box 261											
Yes			World War II			208-09-8816			Helen L. Nelson - Harpers Ferry, W V 25425														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY: 410- IMMEDIATE CAUSE (a) 410 Acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) Hypertensive ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)												WEEKS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?											
19c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. TITLE (SPECIFY) M.D. Dr. MEDICAL EXAMINER											
ACTUAL SIGNATURE			Howard N. Weeks									DATE SIGNED Dec 17 '79											
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 580 Northern Dr Hagerstown Md.																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE									
Burial			12/20/79			Mt. Zion Cemetery			Boonsboro, Washington, Md.														
24. FUNERAL DIRECTOR NAME			ADDRESS			P. O. Box 446			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Robert L. Spencer			Harpers Ferry, W. Va.			DEC 28 1979																	
DHMH - 17 (VR A15 ME (5)) 15M7/77																							

RECORDED

RECORDED

ABH

RECORDED

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31831



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILL-IN. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST Ruby	MIDDLE K	LAST Kathleen Nixon	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH Rec 9 1979	DAY 11 30	YEAR M	2b. HOUR 11 30	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH Dec 7 1979	DAY 11 30	YEAR M	2d. HOUR 11 30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			WICHINGTON		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington County Hospital				Waitress			Restaurant		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			92 West Washington Street			
Maryland	Washington	Hagerstown									
14. FATHER'S NAME FIRST Calvin		MIDDLE Layman	LAST Myers	15. MOTHER'S MAIDEN NAME FIRST Vera		MIDDLE Kathleen	LAST Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		8508 Cunningham Dr.			
No		220-42-5959		Mrs Vera K. Heffner		College Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal skull fracture</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>8147</u> BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>814</u> Vehicle hitting pedestrian											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET <u>W. Washington St.</u>		CITY OR TOWN <u>Hagerstown</u>		COUNTY <u>Washington</u>		STATE <u>Md.</u>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		TITLE (SPECIFY) M.D. <u>Dep</u>		MEDICAL EXAMINER		DATE SIGNED <u>Dec 8 79</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>Howard N. Weeks</u>		ADDRESS <u>580 Northam Av Hagerstown Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>12-8-79</u>		23c. NAME OF CEMETERY OR CREMATORIALY <u>Smithsburg Crematory</u>		23d. LOCATION CITY OR TOWN <u>Smithsburg, Washington, Md.</u>					
24. FUNERAL DIRECTOR NAME <u>A.K. Coffman Funeral Home, Inc.</u>		ADDRESS <u>Hagerstown, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 13 1979</u>						25b. REGISTRAR'S SIGNATURE <u>Victory McBrady</u>	

16. *Lesson 10: The coming of the Moors and*

the Moors in Spain

1. The Moors in Spain

2. The Moors in Spain

3. The Moors in Spain

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18. The Moors in Spain

19. The Moors in Spain

20. The Moors in Spain

21. The Moors in Spain

22. The Moors in Spain

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be witnessed within 24 hours after death. Signature 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical committee that designed and

Item 5 8538 12/19/79 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 3 1 8 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
John William Norris Sr					12-03-79				1:29 a.m.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 09 DAY 17 YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wash. Co.					
10. CITY OR TOWN OF DEATH Hancock, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fleming Trailer Court		12a. USUAL OCCUPATION State Highway Admin. Roads Dept.		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.		13b. COUNTY Washington	13c. CITY OR TOWN Hancock	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. MOTHER'S MAIDEN NAME Estella Rosetta Hiles		15. STREET ADDRESS Box 175 Fleming Trailer Ct.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Yes 1937-1940 217 18 8283		17. INFORMANT Mrs. Ellen B. Norris same as 13.		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		410- Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
		DUE TO, OR AS A CONSEQUENCE OF (b)								
		DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) and not view the body after death										
22b. SIGNATURE Robert Grossweiler		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Grossweiler		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-79		23c. NAME OF CEMETERY OR CREMATORIAL Mahnes Chapel		23d. LOCATION CITY OR TOWN Morgan		COUNTY	STATE W. Va.	
24. FUNERAL DIRECTOR NAME Grove Funeral Home		ADDRESS Hancock, Md.		25a. DATE REC'D. BY REGISTRAR 12-5-1979		25b. REGISTRAR'S SIGNATURE John Morgan				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD 'PENDING' IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												9	3	1	8	3	9			
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
HARRY			EDWARD			OVELMAN						DEC. 2	1979			1:00				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH DAY		YEAR	2d. HOUR		
MALE		White		Mar 6, 1910		69 yrs.						DEC. 2			1979			8:00		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Ohio			U.S.A.			NEVER MARRIED DIVORCED			WASHINGTON											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown			Washington County Hospital			Cook			Restaurant											
13. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS											
Maryland			Washington		Hagerstown		YES <input checked="" type="checkbox"/>		45 South Potomac Street											
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST											
Warren			T.			Elizabeth			McGinnis											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
No			214-14-6089			Robert G. Ovelman			113 Thornton Court Culpeper, Va. 22701											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #414 - MYOCARDIAL INFARCTION												MOMENTS								
410 - Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.												DUE TO, OR AS A CONSEQUENCE OF								
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE #429												10 - 15 yrs.								
(c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?								
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <i>Edward W. Ditto, III</i>												TITLE (SPECIFY) DEPUTY M.D. MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT) <i>Edward W. Ditto, III, M.D.</i>												ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 12-4-79			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.											
24. FUNERAL DIRECTOR NAME <i>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</i>												25a. DATE REC'D. BY REGISTRAR DEC 5 1979			25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>					

GOALS DEMONSTRATION

IMPLEMENTATION

RESULTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

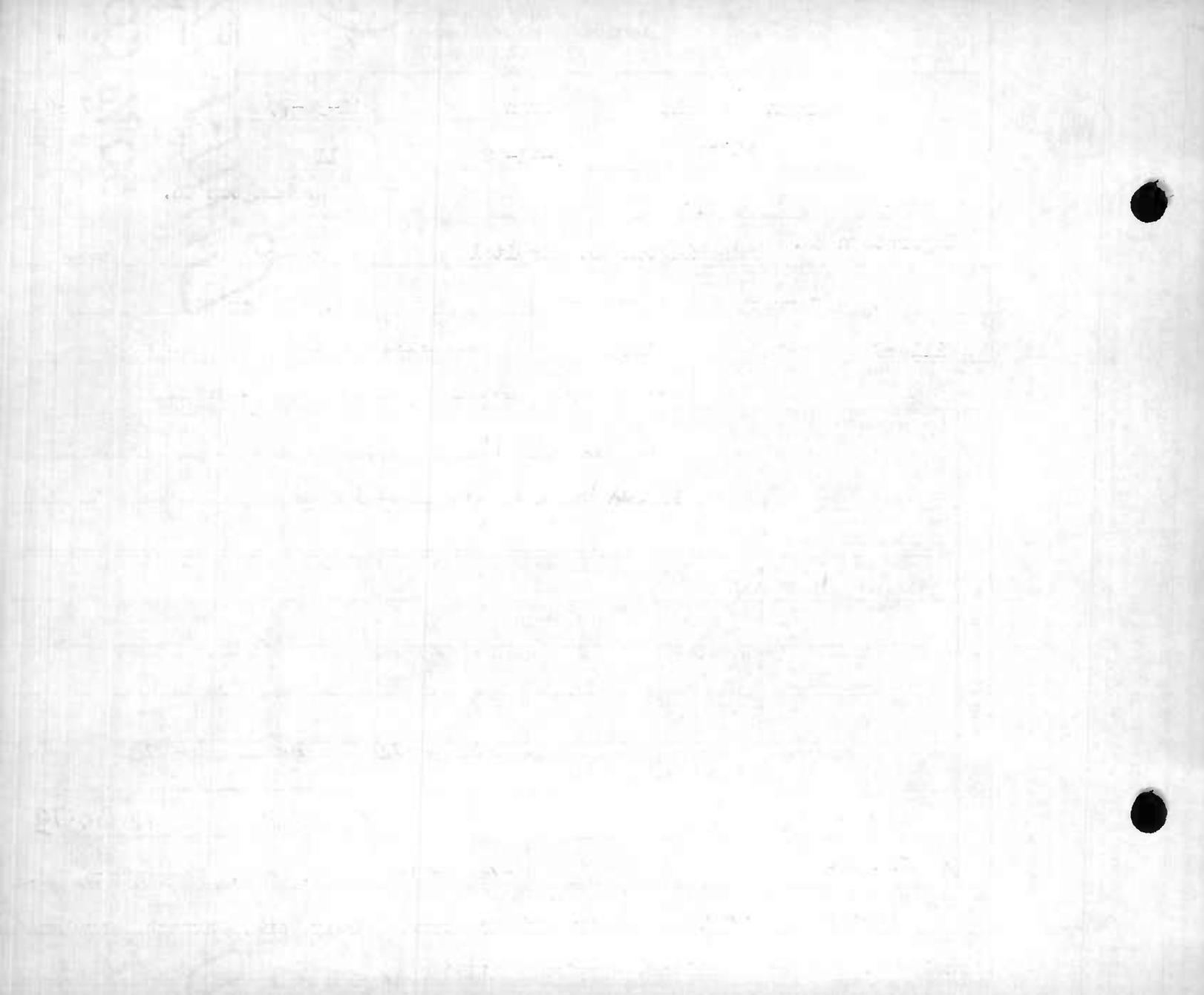
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 4 0		
REG. NO.														
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Russell Curtis Parr						Dec. 7, 1979			7:40 AM		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7c. IF UNDER 1 YEAR MONTHS DAYS		7d. IF UNDER 24 HRS HOURS MIN		
Male		White		Aug. 28, 1895			84 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.							
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative			12b. KIND OF BUSINESS OR INDUSTRY Government							
13a. STATE Virginia		13b. COUNTY Alexandria		13c. CITY OR TOWN Alexandria			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 115 E. Monroe Avenue				
14. FATHER'S NAME FIRST MIDDLE LAST		William Parr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			Mamie Larson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW I		16c. INFORMANT Mrs Esther W. Parr			17. ADDRESS 115 E. Monroe Avenue Alexandria, Va. 22103							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>485- Sudden Bronchopneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebrovascular accident - congestive heart failure</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1, 1979</u> to <u>Dec. 7, 1979</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED <u>Dec. 8, 1979</u>		
22c. SIGNATURE <u>Gloria F. Parr</u>		22d. DEGREE			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Gloria F. Parr		22g. ADDRESS 382 S. CLEVELAND Ave. HAGERSTOWN												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-8-79		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory			23d. LOCATION CITY OR TOWN Smithsburg, Washington, Md.							
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagers town, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 13 1979			25b. REGISTRAR'S SIGNATURE <u>McCreedy</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	3	1	8	4	1			
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Sherman			Dale						Paugh			12-30-79						7:39 AM		
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH 9-21-68			DAY YEAR			11			MONTHS	YEARS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			USA									Washington Co.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown Md.			Washington Co. Hospital									Invalid			None					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Md.			Garrett			Deer Park						Rt. #3, Box 278								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Willard			Dale			Paugh			Patricia			Faye			Warnick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. ADDRESS			16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No			213-92-6078			Willard D. Paugh, See #13 above														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																				
7598 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Brain death								
DUE TO, OR AS A CONSEQUENCE OF (b) Rubinstein-Taybi Syndrome																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Severe disorder																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12-13-78 to 12-30-79, that (I) (we) last saw the deceased alive on 12-2-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE R. FARAH												DEGREE								
22c. PHYSICIAN'S NAME (TYPE OR PRINT) R. FARAH												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. ADDRESS c/o Washington Co. Hosp., Hagerstown, Md.												22e. DATE SIGNED 12-30-79								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE					
burial			1/2/80			Deer Park Cemetery			Deer Park			Garrett, Maryland								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Bradley A. Stewart			Oakland, Maryland 21550																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	3	1	8	4	2
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Lorraine			NM		F		Purnell		12-18-79					M		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH 09 26 97			6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
7a. BIRTHPLACE Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.							
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Colton Villa Nursing Home			12a. USUAL OCCUPATION Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hancock		13d. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 171 W. Main St.							
14. FATHER'S NAME Lewis			15. MOTHER'S MAIDEN NAME Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-30-9292			17. INFORMANT Mrs. Merrill Sipes			ADDRESS 171 W. Main St., Hancock, Md.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours						
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c) b) DUE TO, OR AS A CONSEQUENCE OF b) DUE TO, OR AS A CONSEQUENCE OF c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) AS CVD																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1976</u> to <u>12-18-79</u> , that (I) (we) last saw the deceased alive on <u>12-4-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Vasant Datta			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-19-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, M.D.			22e. ADDRESS 1600 OAK HILL AVE., HAGERSTOWN, MD 21740													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/21/79			23c. NAME OF CEMETERY OR CREMATORIAL Catalpa Methodist			23d. LOCATION CITY OR TOWN Rural Hancock Wash. MD.		COUNTY	STATE				
24. FUNERAL DIRECTOR NAME Richard J. Shaw			ADDRESS Hancock MD			25a. DATE REC'D. BY REGISTRAR DEC 28 1979.			REGISTRAR'S SIGNATURE R. J. Shaw							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be made.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 8 4 3				
										REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST							
NORMAN OSCAR PUTMAN SR										DEC 24- 1979				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
MALE		WHITE		MARCH 19-1925			54							
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
MARYLAND		USA					WASHINGTON			HAGERSTOWN				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							12b. KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN WASHINGTON Co HOSPITAL		MAINTENANCE							STATE HOSPITAL					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS				
13a. STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			310 S PETOMAC ST.				
14. FATHER'S NAME FIRST ROY			MIDDLE G		LAST PUTMAN		15. MOTHER'S MAIDEN NAME FIRST ALTA			MIDDLE I		LAST DUVALL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			214-36-5756			BOWERS & ADDRESS RD NORMAN O PUTMAN JR NEW WINDSOR MD			Cardio-respiratory arrest				immediate	
4149				DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease and								years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy								years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Generalized arteriosclerosis				
19a. DATE OF OPERATION 12-23-79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 78 to Dec 19 79, that (I) (we) last saw the deceased alive on 12/21 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12-24-79				
22b. SIGNATURE W S Hood			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W S Hood			22e. ADDRESS 645 E 1st St Hagerstown Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC 28-1979			23c. NAME OF CEMETERY OR CREMATORIUM LORRAINE PARK			23d. LOCATION CITY OR TOWN BALTIMORE			COUNTY STATE		
24. FUNERAL DIRECTOR NAME D D Hartzler			ADDRESS New Windsor Md			25a. DATE REC'D. BY REGISTRAR DEC 28 1979			25b. REGISTRAR'S SIGNATURE Patsy Melody					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be summoned.

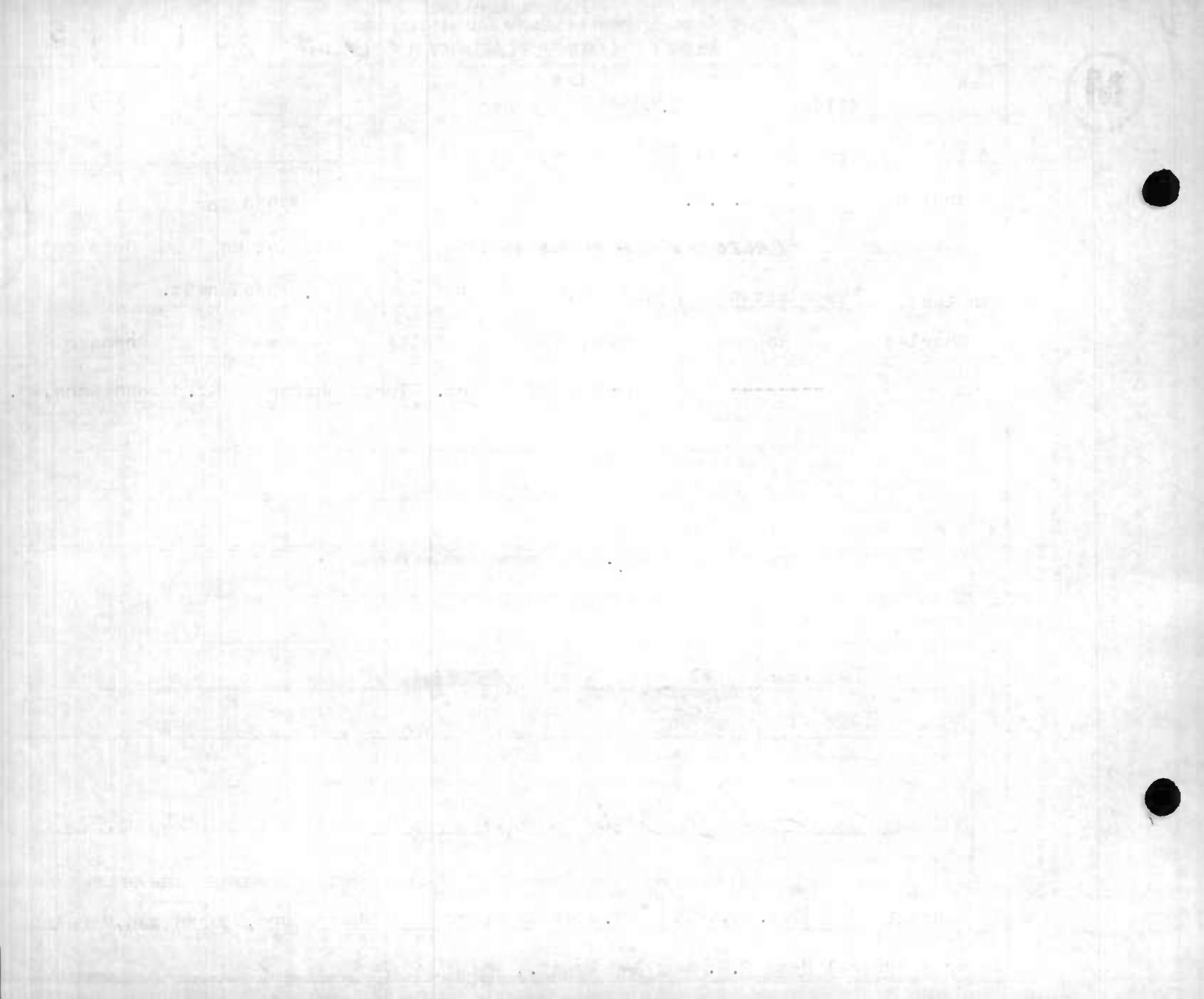
MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 8 4 4 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
HENRY RUSSELL RAYMOND										12 25 79				8 10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS	
MALE		WHITE		2		2		1894		85		YRS		MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
NEW YORK		USA												WASHINGTON Co. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
WILLIAMSPORT		Homewood RETIREMENT CENTER										12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Washington		Hagerstown				36 Pin Oak Terrace							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
EDWARD		R.		RAYMOND		ELIZABETH				HICKSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
EX-ARMED FORCES		YES W.W. I		218-34-3770		ADMISSION RECORD 2750 VA. AVE WILMST. MD.		HOMEWOOD RET CENTER		24 hrs.					
4409		DUE TO, OR AS A CONSEQUENCE OF b) Generalized arteriosclerosis with c) DUE TO, OR AS A CONSEQUENCE OF (c)		10 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11- saw the deceased alive on 10 dec. 24 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										12-26-79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE					
Burial		12-28-79		St. Mark's Cemetery		Lappans, Wash. Co., Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
John H. Bast, Jr.		Boonsboro, Md. 21713		DEC 28 1979		F. J. McCreedy									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31845				
1- STATE REGISTRAR			Lee									2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 21 1979 12AM 45				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. HOUR				
William						COLUMBUS			Renner			12AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		
Male		White		Oct. 27, 1906			73 yrs.							Dec. 21 1979 12AM 45		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			U.S.A.						Washington							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			COLTON VILLA NURSING CENTER									Dietitian			Hospital	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Washington		Sharpsburg						308 W. Chapline St.					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
Charles			Raymond			Renner			Della Mae						Drenner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			214-09-5330			Mrs. Gloria Shafer			Rt. 1 Boonsboro, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> Code 038 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subdural Hematoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Auto Accident</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION <u>Sept. 12, 1979</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Subdural Hematoma</u>									20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>1240 P.M. Sept. 9, 79</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Collision with another auto</u>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Rt. 65</u>			21f. LOCATION STREET <u>nr. Fairplay</u>			CITY OR TOWN <u>Washington</u>			COUNTY <u>MD</u>		STATE		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <u>H. N. Weeks</u>			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <u>580 Northern Ave. Hagers. MD</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Dec. 24, 1979</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. View Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Sharpsburg, Washington, Maryland</u>			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <u>Osborne Funeral Home</u>			ADDRESS <u>P.O. Box 348 Wmspt.</u>			25a. DATE REC'D. BY REGISTRAR <u>Dec. 28 1979</u>			25b. REGISTRAR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	4	6					
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Ralph B. Rhodes												December 10, 79						1630 M					
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
Male			White			MONTH DAY YEAR			85			MONTHS DAYS			HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland			U.S.A.			Dec. 18, 1893			Washington			Big Spring			Residence RFD-1 Big Spring			Farmer			Farming		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Maryland			Washington			Big Spring			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD-1			Jacob			Sophia F. Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			ADDRESS			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No									arteriosclerotic heart disease						4140								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b)									DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 79</u> , 19 <u>1970</u> to <u>12-10</u> , 19 <u>1979</u> that (I) (we) last saw the deceased alive on <u>Nov 19 79</u> , 19 <u>1970</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						12-11-79											
Eldon Leon Hawbaker M.D.						645 E. 1st St., Hagerstown, Md. 21740																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
Burial			Dec. 13, 79			St. Pauls			Clearspring, Wash. Md.														
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Richard E. Hawbaker																							
Thompson Funeral Home						Clearspring, Md.			DEC 17 1979														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 411-793-3542.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 4 7		
											REG. NO.			
1 - STATE REGISTRAR			Herbert Lewis Rice											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
HERBERT LEWIS RICE						RICE		12/2/79				1979		
3 SEX		4 RACE		5 DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH June		DAY 21	YEAR 1911	68		MONTHS	YEARS	MONTHS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
District of Columbia		U.S.A.		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Washington County						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown		Washington Hospital		Painter		Contractor								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>	206 North Locust Street					
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		LAST				
William		D.				Rice		Eleanor		Lewis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		18. ADDRESS								
Yes		W.W. II		218-07-3542-A		Mrs Mary Y. Rice		206 North Locust Street		Hagerstown, Md. 21740				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a)														
2080 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any												CVD		
DUE TO, OR AS A CONSEQUENCE OF (b)												Acute Leukemia -		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/2/79, 1979, to 12/2/79, 1979, that (I) (we) lost saw the deceased alive on 12/2/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) did (did not) view the body after death.														
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED								
W. Lewis Wooster		MD				12/3/79								
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS		1825 Hagerstown, Md.										
Burial		12-5-79		Cedar Lawn Memorial Pk.		Hagerstown, Washington, Md.		COUNTY			STATE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN								
Burial		12-5-79		Cedar Lawn Memorial Pk.		Hagerstown, Washington, Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
A.K. Coffman Funeral Home, Inc.		Hagerstown, Md.		DEC 5 1979		Hagerstown								

Helpful Terms

HEBBEL FEST 1974

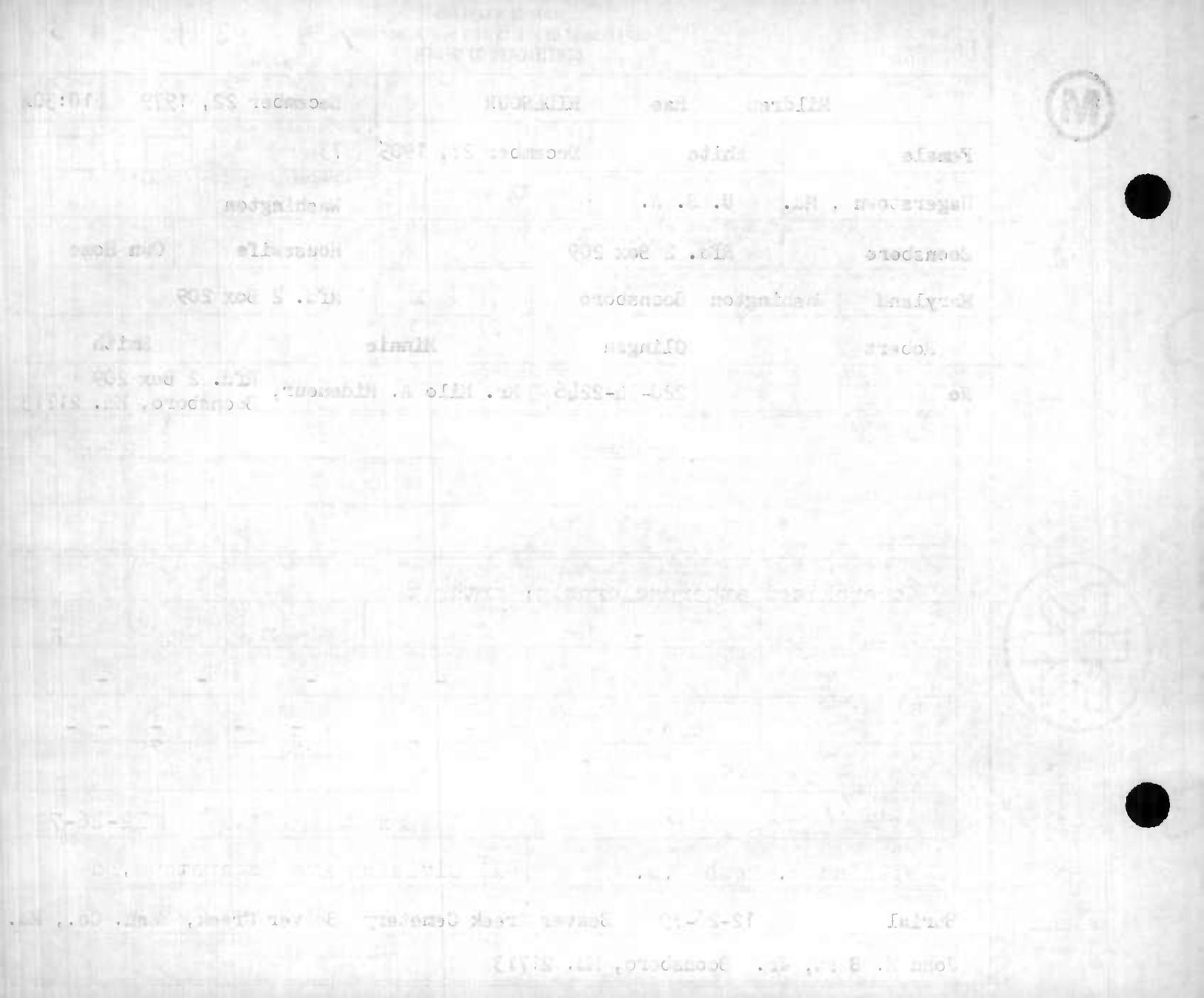
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR									
Mildred Rae RIDENOUR						December 22, 1979				10:30A M									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female		White		Month December Day 27, Year 1905		73		MONTHS		DAYS HOURS MIN									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Hagerstown, Md.		U. S. A.				Washington													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Boonsboro		Rfd. 2 Box 209				Housewife		Own Home											
13a. STATE Maryland												13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 2 Box 209	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		Smith									
Robert				Clingan		Minnie													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS		17. INFORMANT Mr. Milo A. Ridenour, Rfd. 2 Box 209 Boonsboro, Md. 21713		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No		220-34-2246						2 mos											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY.																			
IMMEDIATE CAUSE (a) Leukemia																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
Generalized atherosclerosis; arthritis																			
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None		21f. LOCATION STREET -		CITY OR TOWN -		COUNTY -		STATE -									
22a. I certify that (I) (this hospital) attended the deceased from Feb 19 73 to Dec 19 79, that (I) (we) last saw the deceased alive on Dec 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE WW Lesh M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-26-79													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.		22e. ADDRESS 411 Division Ave Hagerstown, Md																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORIAL Beaver Creek Cemetery		23d. LOCATION CITY OR TOWN Beaver Creek, Wash. Co., Md.		COUNTY -		STATE -									
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.		ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.													



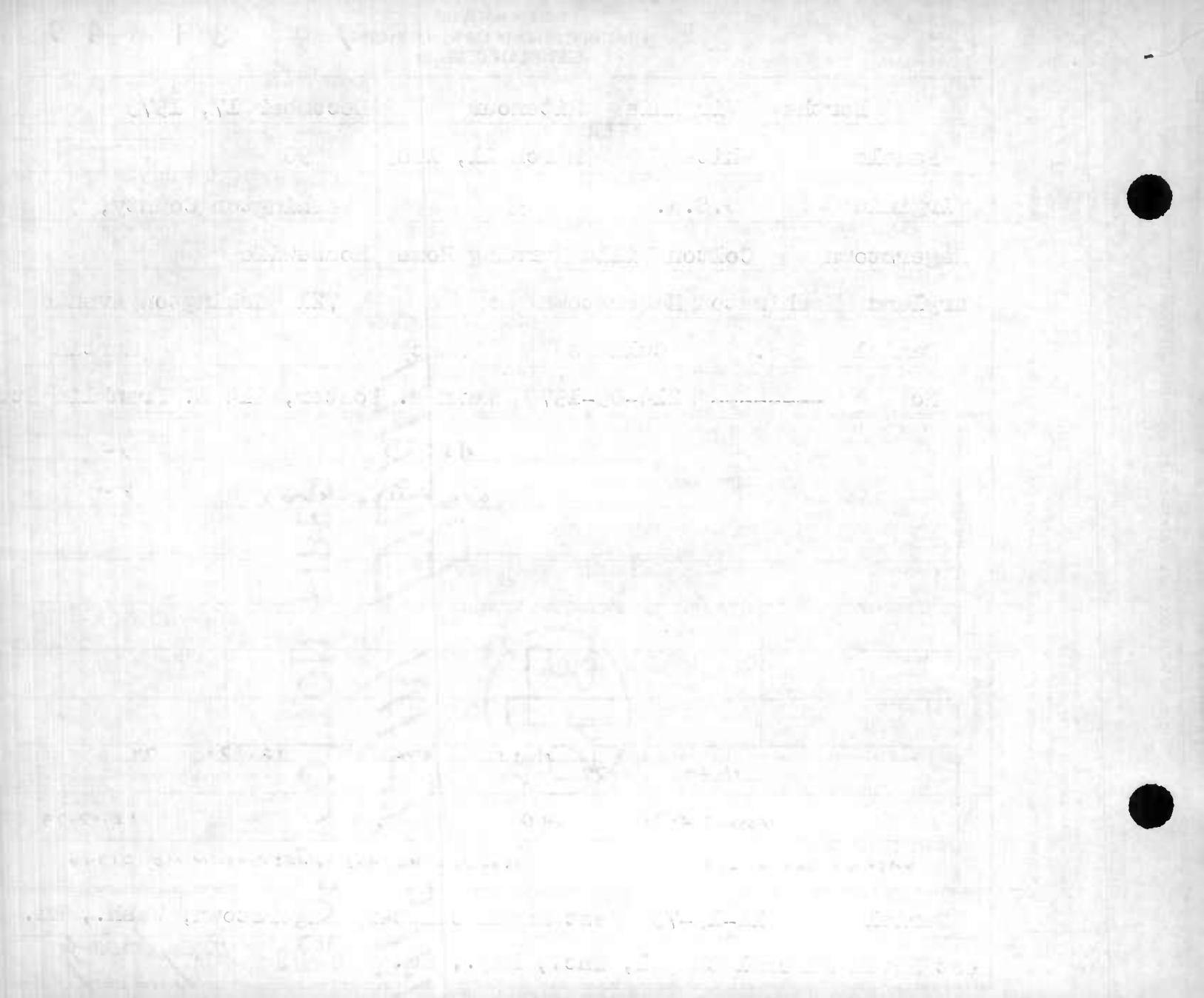
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 9 3 1 8 4 9													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Bertha Virginia Ritenour						December 17, 1979			M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female		White		March 11, 1889			90			YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		U.S.A.					Washington County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Hagerstown		Colton Villa Nursing Home										Housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Washington		Hagerstown						721 Washington Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Daniel F. Cullers		Nancy										Martin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		214-09-1970		Dawn M. Foster, 214 E. Franklin St.						m			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
Gen. Anterior decon's ASUVD													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1976</u> to <u>Dec 17, 1979</u> , that (I) (we) last saw the deceased alive on <u>11, 29, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Vasant Datta		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12.17.79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, M.D.		22e. ADDRESS 1600 OAK HILL AVE, HAGERSTOWN, MD 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-19-79			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION Hagerstown, Wash., Md.					
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hagerstown, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 20 1979			25b. REGISTRAR'S SIGNATURE Lily Shabot					
BP													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 5 0	REG. NO.
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Carl Thornton RODGERS									December 4, 1979			M	
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		Nov. 12, 1903			76 YRS			MONTHS DAYS		HOURS MIN	
8a. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter			12b. KIND OF BUSINESS OR INDUSTRY construction				
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 6, Box 35N2				
14. FATHER'S NAME William K. Rodgers			15. MOTHER'S MAIDEN NAME Annie Stinespring										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO 227-20-4389			17. INFORMANT ADDRESS Virginia S. Rodgers, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Generalized arteriosclerosis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH long standing	
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Parkinsonism, dementia, kyphosis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/16, 1979, to 12/8, 1979, that (I) (we) last saw the deceased alive on 12/3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE R. AMARILLO M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO M.D.			22e. ADDRESS 127 KING ST HAGERSTOWN, MD 21740										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Dec. 7, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Augusta Mem. Park			23d. LOCATION CITY OR TOWN Fiserville, Virginia				
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR DEC 11 1979			25b. REGISTRAR'S SIGNATURE Robert McBrady							

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 5 1							
												REG. NO.							
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 1 P.M.							
George Ralph Rosenberry									Dec. 21, 1979										
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED X NEVER MARRIED WIDOWED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Aircraft		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Big Pool			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD-1			14. FATHER'S NAME John E. Rosenberry		15. MOTHER'S MAIDEN NAME Cora				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 214-09-1197		16c. INFORMANT Mrs. Alice E. Rosenberry			16d. ADDRESS Big Pool			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Large cell carcinoma of Lung												DUE TO, OR AS A CONSEQUENCE OF (b)							
												DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) the hospital attended the deceased from <u>June 1952</u> to <u>Dec. 21, 1979</u> , that (I/we) last saw the deceased alive on <u>Dec 21, 1979</u> , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.												22b. SIGNATURE Walter M. Wally, M.D.		22c. DEGREE					
												22d. ATTENDING PHYSICIAN <input type="checkbox"/>		22e. MEDICAL DIRECTOR <input type="checkbox"/>		22f. STAFF PHYSICIAN <input type="checkbox"/>			
22g. PHYSICIAN'S NAME (TYPE OR PRINT) Walter M. Wally, M.D.												22h. ADDRESS		22i. DATE SIGNED 12-21-79					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 24, 79			23c. NAME OF CEMETERY OR CREMATORIAL Greenway			23d. LOCATION CITY OR TOWN Berkeley Springs, W. Va.			23e. COUNTY STATE							
24. FUNERAL DIRECTOR Donald E. Thompson Thompson Funeral Home						25. DATE REC'D. BY REGISTRAR DEC 27 1979			25b. REGISTRAR'S SIGNATURE J. J. Thompson										
DHMH-16 25M (VRA 15, 4) 1/79																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
John Richard RUMMEL							December 7, 1979			M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS					
male		white		February 15, 1913			62 66			IF UNDER 24 HRS MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Washington					
Maryland		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown		931 Salem Avenue								railroad					
13a. STATE 13b. COUNTY Maryland Washington Hagerstown												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 931 Salem Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Richard M. Rummel				Florence Loudenslager											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS									
No		214-09-5252		Mary C. Rummel, Hagerstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u>												min.			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>												min.			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis + Prior M.I.'s</u>												Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21g. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 19 70 to 7 Dec 79, that (1) (we) last saw the deceased alive on 30 Nov 19 71, and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.												22c. DATE SIGNED 1/2/79			
22b. SIGNATURE <u>Johns</u>		22d. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson, M.D.		22f. ADDRESS P.O. Box 1826, Hagerstown, Md. 21740													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 10, 1979		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		STATE						
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR DEC 11 1979						25b. REGISTRAR'S SIGNATURE <u>Johns</u>							

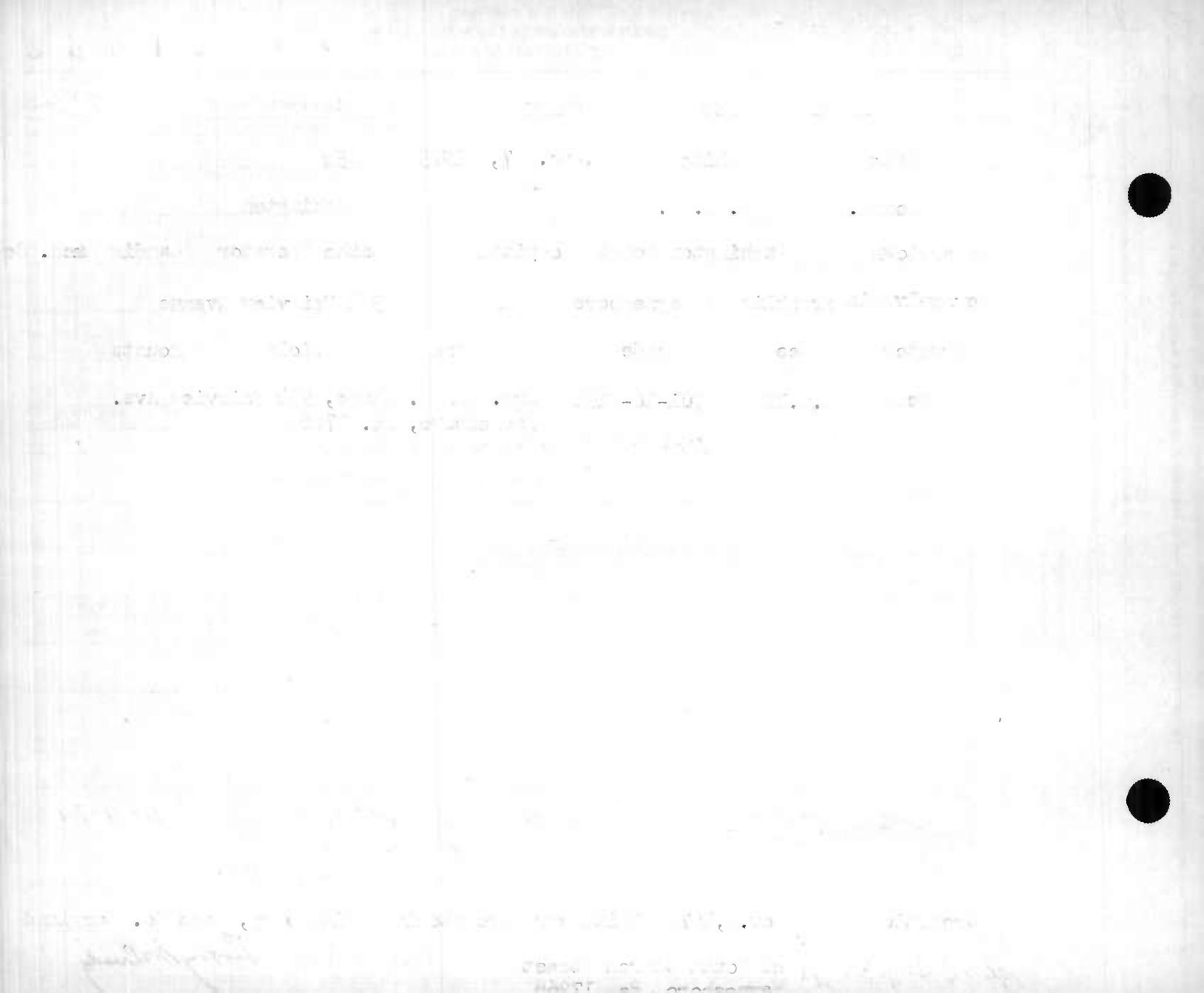
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG NO. 1931853																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR														
PARKER			LEE			SHADE			NOVEMBER			8	1979		5:50 pm														
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN																
Male		White		Jan. 7, 1925			54 yrs.																						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Penns.		U. S. A.					Washington			Hagerstown			Washington County Hospital			Lathe Operator			Landis Mach. Co.										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. ADDRESS		13g. ADDRESS		13h. ADDRESS		13i. ADDRESS		13j. ADDRESS											
Pennsylvania		Franklin		Waynesboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		924 Fairview Avenue																					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
Truster Lee Shade			Edna Viola Mountz			201-16-2198			Mrs. Ann G. Shade, 924 Fairview Ave.						Mass Diagnos is Bilateral Pulmonary embolism			5 mins.											
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES, W.W. II			18b. SOCIAL SECURITY NO			18c. IMMEDIATE CAUSE (a)			18d. DUE TO, OR AS A CONSEQUENCE OF (b) Daen Venus Thrombosis extensive			18e. DUE TO, OR AS A CONSEQUENCE OF (c) Bed rest Post-operatively			18f. REPORT OF AUTOPSY			18g. 1 week											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		3 weeks											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Release of nerves & tendons - right arm			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																				
19c. DATE OF OPERATION 10/23/79			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A																							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Factory			21f. LOCATION STREET Landis Co. CITY OR TOWN Waynesboro, Pa. COUNTY STATE																				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE BARRY M. COHEN			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 11-9-79																				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN			22f. ADDRESS 1198 KENLY HVE HAGERSTOWN, MD. 21780			22g. ADDRESS 48 South Church Street Waynesboro, Pa. 17268			22h. LOCATION CITY OR TOWN Smithsburg, Wash Co. Maryland			22i. COUNTY STATE																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Nov. 8, 1979			23c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Crematorium			23d. LOCATION CITY OR TOWN Smithsburg, Wash Co. Maryland			23e. DATE REC'D. BY REGISTRAR NOV 14 1979			23f. REGISTRAR'S SIGNATURE Patsy McCreedy														
24. FUNERAL DIRECTOR NAME John Smoyer Jr.			24b. ADDRESS 48 South Church Street Waynesboro, Pa. 17268			24c. DATE REC'D. BY REGISTRAR NOV 14 1979			24d. REGISTRAR'S SIGNATURE Patsy McCreedy																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 5 4						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Alice Rebecca Shank			Alice			Rebecca			Shank			December 18, 1979					M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
Female		White		Month June 2, 1897 Year			82 YRS			MONTHS		DAYS		HOURS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Maryland		U.S.A.					Washington											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Washington County Hospital		Floor Lady			Printing & Bookbinding											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Washington		Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Walnut Lane									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																
Francis		Middle Marion	Last Rickard	First Mary			Catherine Palmer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS											
No		214-09-7204		Mrs. Vivian Wasilius			289 Frederick Street											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 1. DEATH WAS CAUSED BY		min																
IMMEDIATE CAUSE (a)		Cardiorespiratory arrest																
4379																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF																
		(b) Cerebral vascular insufficiency, multiple																
		DUE TO, OR AS A CONSEQUENCE OF																
		(c) Respiratory failure																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 5, 1979, to Dec 17, 1979, that (I) (we) last saw the deceased alive on Dec 17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED										
C. C. SU		MD																
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)													
C. C. SU		239 N. Potowmack St.			Burial													
23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE							
12-20-79		Rose Hill Cemetery			Hagerstown, Washington, Md.													
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE	
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.					DEC 24 1979												McBrady	

1000' ground truth

100

Very soft

Indicates very soft soil with no cohesion

Stiff

Indicates stiff soil with no cohesion and no

real or significant shear

resistance holding slopes

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

31855
REG. NO.

1 - STATE REGISTRAR			2a. DATE KNOWN OF ESTI. DEATH MATED										2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<input checked="" type="checkbox"/> MONTH		DAY		YEAR		4:30 P.M.			
John			Gilbert			Shawyer			<input checked="" type="checkbox"/>		ESTI.		DEATH		MATED		Dec. 10 1979				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. MONTH		DAY		YEAR		2d. HOUR 6:55 P.M.	
Male		White		Dec. 28 1956		22 yrs.		MONTHS		DAYS		HOURS		MIN		Dec. 10		1979			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.							
Maryland		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Washington		Carpenter		Blue Mt. Cons.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Bakersville			Tommytown Rd. RE. 1 Sharpsburg									Carpenter			Blue Mt. Cons.						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
Maryland			Washington		Hagerstown			<input checked="" type="checkbox"/>			424 Mitchell Ave.										
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																		
FIRST Gilbert			MIDDLE Hildon			LAST Shawyer			FIRST Florence			MIDDLE Jean			LAST Paul						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
NO			219-66-1354			Diane L. Shawyer			(see # 13 e)												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 806 - 7x Cervical vert															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant						
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) 810 - Motor Vehicle - Train collision																					
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?									
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET Tommy Rd RE. 1 CITY OR TOWN Sharpsburg COUNTY WASH STATE Md.															
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion															
ACTUAL SIGNATURE <i>Harold R. Teitch</i>			TITLE (SPECIFY) M.D. <i>ASST.</i>			MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT) <i>Harold R. Teitch</i>			ADDRESS <i>138 E. Anneram St</i>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec. 14, 1979</i>			23c. NAME OF CEMETERY OR CREMATORIY <i>Mountain View Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Sharpsburg</i>			COUNTY <i>Washington</i>			STATE <i>MD</i>						
24. FUNERAL DIRECTOR NAME <i>Osborne Funeral Home</i>			ADDRESS <i>P.O. Box 348 Wmspt., MD</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 24 1979</i>			25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>												

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31856					
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED									2b. HOUR 6:38 P.M.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			MONTH DAY YEAR			19					
Julian Lee Sawyer																	
3. SEX M RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR 6:38 P.M.	
			Dec. 31, 1957			21 yrs.							Dec. 10, 1979			6:35 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sharpsburg MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington								
10. CITY OR TOWN OF DEATH Bakersville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Tommutoyton Rd. Rt. 1 Sharpsburg			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Bakersville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 325 Sharpsburg, MD						
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert Hildon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Jean Paul														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-78-1157			17. INFORMANT			ADDRESS Gilbert H. Shawyer (see item 13e)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8109 SKULL FRACTURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) AUTO-TRAIN ACCIDENT. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED 12/11/79					
ACTUAL SIGNATURE Harold R. Trutch Jr.			TITLE (SPECIFY) M.D. assist.			MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) HAROLD R. TRUTCH JR.			ADDRESS 138 E ANTIEFAN ST			AGERSTADT, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 14, 1979			23c. NAME OF CEMETERY OR CREMATORIAL View Cemetery			23d. LOCATION CITY OR TOWN Sharpsburg		COUNTY Washington		STATE MD				
24. FUNERAL DIRECTOR NAME Osborne Funeral Home			ADDRESS P.O. Box 348 Wmspt., MD			25a. DATE REC'D. BY REGISTRAR DEC 24 1979			25b. REGISTRAR'S SIGNATURE <i>harry h. trutch</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
Lillian Katherine Shores							Dec. 23, 1979										
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR							
Female		White		MONTH	DAY	YEAR	81			IF UNDER 24 HRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN							
Maryland		USA					Washington										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Homewood Retirement Center								secretary			retail				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland Washington Hagerstown															Longmeadow Apts.		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS			LAST						
unk.				Moran	Laura			--			McCreary						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
no		215 10 7195					cachexia			wks							
1539			DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma						7 mo								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma of colon						9 mo								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from 7/7/77 to 12/30/77, that (I) (we) last saw the deceased alive on 12/14/77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22c. DATE SIGNED 12/24/79					
22b. SIGNATURE Harold R. Tritch Jr. MD		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold R. Tritch Jr. MD		22e. ADDRESS 138 E. Amsterdam ST															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-79		23c. NAME OF CEMETERY OR CREMATORIAL Gettysburg Nat.			23d. LOCATION CITY OR TOWN Gettysburg, Penna.		COUNTY STATE								
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		ADDRESS 305 N. Potomac St. Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 28 1979			25b. REGISTRAR'S SIGNATURE Gerry Minnich										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			8:00 A.M.		
Mary		Elizabeth		Sigler			December 30, 1979			P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS		
Female		White		May 16, 1904			75 YRS.			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.					Washington Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington Co. Hospital		Housewife			Own Home					
13a. STATE Md.		13b. COUNTY Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 106 S. Main St.					
14. FATHER'S NAME FIRST HARRY		MIDDLE		LAST LAPOLE			15. MOTHER'S MAIDEN NAME FIRST MAZIE MIDDLE			LAST MOSER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			17. ADDRESS					
NO		212-76-1651		Earl G. Sigler			Middletown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												4 years
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease												4 years
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Obesity, malnutrition												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 3-31-1961 to 12-18-1979, that (1) (was) lost soul the deceased alive on 12-18-1979, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (was) (did not) view the body after death.												22b. DATE SIGNED
22b. SIGNATURE John Secondari		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			12-31-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SECONDARI		22e. ADDRESS Boonsboro 21712										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1980		23c. PLACE OF BURIAL/CREMATORIUM Ch. of Brethren			23d. LOCATION CITY OR TOWN Middletown			COUNTY Fred. Md. STATE		
24. FUNERAL DIRECTOR NAME Gladhill Co. Middletown, Md.		ADDRESS 21769		25a. DATE REC'D. BY REGISTRAR JAN 4 1980			25b. REGISTRAR'S SIGNATURE Henry McBrady					

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1990-1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner/must be notified at once.

Item 5 8539 1/30/80 BJ

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 8 5 9

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
BERTHA Lou Slaughter						December 20, 1979				7:00 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		MONTH	DAY	YEAR	83				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Virginia		USA				Washington County, MD.			Hagerstown		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Avalon Manor Nursing Home										Housewife	
13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Pleasantville										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Harpers Ferry Road	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
Lewis			Rodney	Edwards	Lourinda			Ross	Hackley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 232-62-9618			17. INFORMANT			ADDRESS Route 1, Box 170		
No						Garland F. Slaughter - Harpers Ferry, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardiac Arrest										(4029)	
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Vascular Disease										(4029)	
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis - Generalized											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 5-4 19 78 to 12 19 79 , that (I) <input type="checkbox"/> saw the deceased alive on 12-16-79 19 79 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) <input type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>Clark A Hoffman</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lloyd A. Hoffman</i>		22e. ADDRESS 11470 212 Hill Ave									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 21/24/79		23c. NAME OF CEMETERY OR CREMATORIAL Pleasant View Mem. Gar.		23d. LOCATION CITY OR TOWN Martinsburg		COUNTY Berkeley	STATE WV		
24. FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, W. Va.		ADDRESS Robert L. Spencer - Harpers Ferry, W. Va.		25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE <i>Robert L. Spencer</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 6 0	REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			12/2/79			6:50 PM		
6-7. SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		# UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			79 YRS.		MONTHS DAYS HOURS MIN			
8. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SalesMan			12b. KIND OF BUSINESS OR INDUSTRY Stock foods								
13a. STATE Md.			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 343 Cherrytree Circle					
14. FATHER'S NAME George G. Smith			15. MOTHER'S MAIDEN NAME Nannie May Jessop														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO 214-09-0513			17. INFORMATION Circled Hagerstown Md. 21740 Mrs. Arabelle G. Smith 343 Cherrytree						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Obstructive Disease</i>																	
4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Myocarditis Corde-vae. Disease</i> (c) <i>Widespread congestive Heart failure</i>												9 yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. X 19			21c. HOW INJURY OCCURRED X			21d. NATURE OF INJURY (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> X			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) X			21g. LOCATION STREET X CITY OR TOWN X COUNTY X STATE X											
22a. I certify that (I) (this hospital) attended the deceased from 1976, 19, to Dec. 2, 1979, that (I) (we) last saw the deceased alive on Dec. 2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												23e. DATE SIGNED 12/3/79					
22b. SIGNATURE <i>John Deering MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. B. KNEISLEY			22e. ADDRESS 148 W. Washington St. Hagerstown, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/5/79			23c. NAME OF CEMETERY OR CREMATORIAL Stenger Hill			23d. LOCATION CITY OR TOWN Peters Twp. Franklin Pa.			COUNTY STATE					
24. FUNERAL DIRECTOR <i>John Deering</i>			25a. ADDRESS 17236 Mercersburg, Pa.			25b. DATE REC'D. BY REGISTRAR DEC 11 1979			25c. REGISTRAR'S SIGNATURE <i>George Deering</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 8 6 1				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
John Lewis			SMITH			Jr.			December 19, 1979					
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 12, 1911			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington		MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bar tender			12b. KIND OF BUSINESS OR INDUSTRY motel						
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 519 N. Mulberry						
14. FATHER'S NAME John L. Smith, Sr.		15. MOTHER'S MAIDEN NAME Mary T. Lawrence												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 214-09-5181A			17. INFORMANT Myrtle A. Smith, Hagerstown, Md.			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESP. ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal insufficiency/ congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung abscess/ Bronchogenic carcinoma.</u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/15/75</u> to <u>12/19/75</u> , that (I) (we) last saw the deceased alive on <u>12/15/75</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22b. DATE SIGNED 12/20				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Dwight Booster, M.D.		22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL buriel		23b. DATE Dec. 21, 1979			23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland						
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR DEC 24 1979			25b. REGISTRAR'S SIGNATURE Loyalty DeBandy									
ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740														

0-785-51119-2 (International Books) 3587

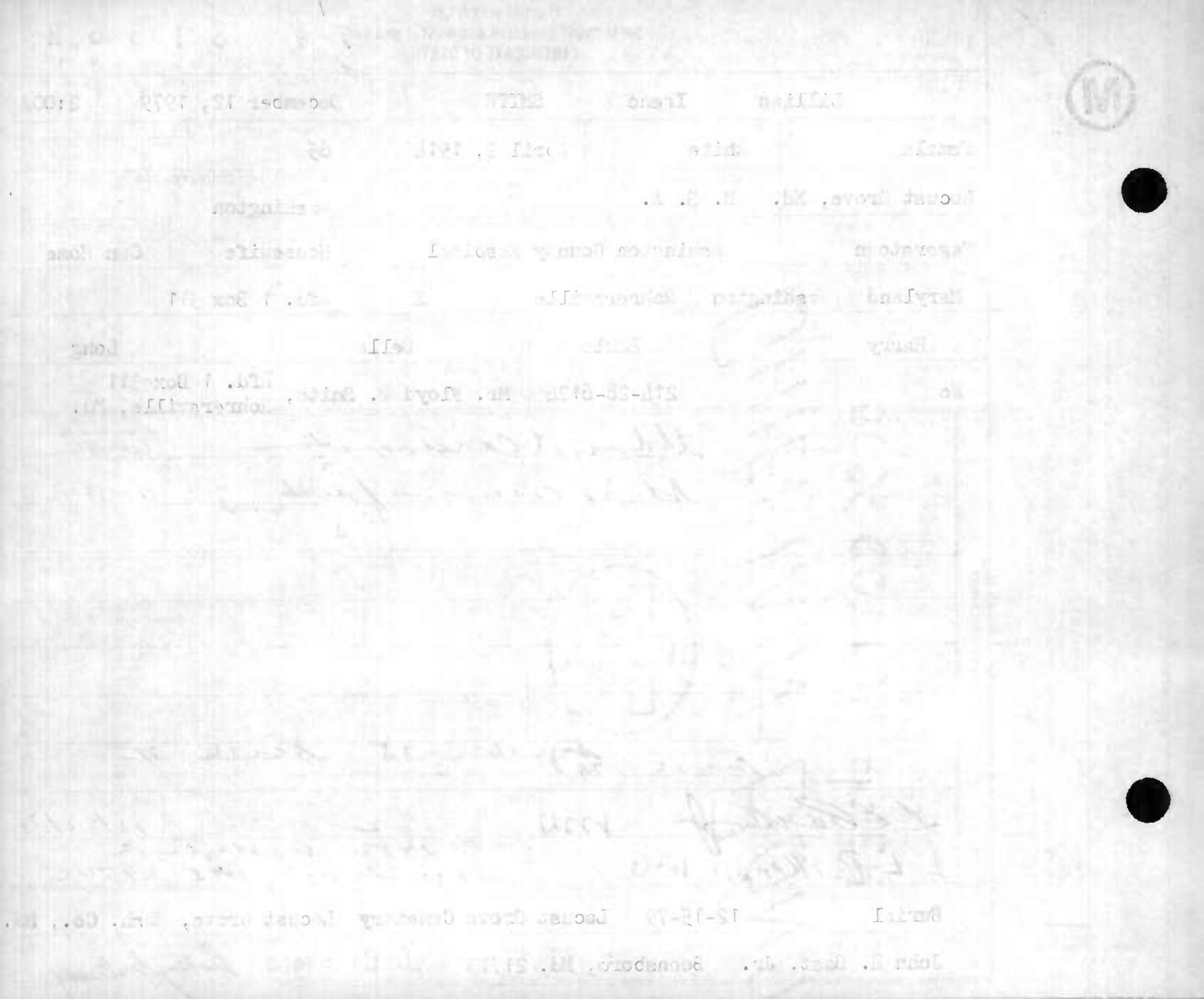
G.M. *retroflex* *trivitt* I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-to-cost permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 9 3 1 8 6 2																							
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			December 12, 1979			2:00A _M																							
Lillian Irene SMITH																																			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.																							
						April 2, 1914			65																										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Locust Grove, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			10. CITY OR TOWN OF DEATH Hagerstown																							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Rohrersville																						
14. FATHER'S NAME FIRST MIDDLE LAST Harry Eakle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Della			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-28-6124			17. INFORMANT Mr. Floyd W. Smith, Rohrersville, Md.																							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN DEATH AND CERTIFICATION			1540			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			19. APPROXIMATE INTERVAL BETWEEN DEATH AND CERTIFICATION																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			21h. COUNTY			21i. STATE			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			21h. COUNTY			21i. STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 16, 1975</u> to <u>Dec 12, 1977</u> , that (I) (we) last saw the deceased alive on <u>Dec 12, 1977</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			22b. SIGNATURE <u>L L Pack Jr. MD</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/12/77			22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 16, 1975</u> to <u>Dec 12, 1977</u> , that (I) (we) last saw the deceased alive on <u>Dec 12, 1977</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			22b. SIGNATURE <u>L L Pack Jr. MD</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/12/77														
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>L L Pack Jr. MD</u>			22f. ADDRESS 145 W. Washington St Hagerstown Md 21713			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-15-79			23c. NAME OF CEMETERY OR CREMATORIUM Locust Grove Cemetery			23d. LOCATION CITY OR TOWN Locust Grove, Wash. Co., Md.			24. FUNERAL DIRECTOR NAME John H. Bast, Jr.			25a. DATE REC'D. BY REGISTRAR DEC 14 1979			25b. REGISTRAR'S SIGNATURE <u>Henry McCreary</u>											



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1863

1. DECEASED NAME (Type or print)		First Thelma	Middle G.	Lost Smith	2a. DATE OF DEATH Dec. 31, 1979	2b. HOUR 3:25 P.M.		
3. SEX Female		4. RACE White	5. DATE OF BIRTH 8 Jan 1946		6. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED		9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 2, Hagerstown, MD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WV		13b. COUNTY Mineral	13c. CITY OR TOWN Ridgeley	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Ridgeley, WV			
14. FATHER'S NAME Adam Ridenour		First Middle Last	15. MOTHER'S MAIDEN NAME nmn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.	17. INFORMANT Thomas Yeargen		Hagerstown, Md. Address Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Renal Adenocarcinoma (Hyperplastic right kidney)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 yrs	
1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
19. MEDICAL CERTIFICATION 19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 12 Sept., 1979, to date, 19, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 12 Sept., 1979, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.								
22b. SIGNATURE Richard T. Binford, M.D.		DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 21 Dec 79.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-24-78	23c. NAME OF CEMETERY OR CREMATORIAL Abe Cemetery	23d. LOCATION (City or Town) Cumberland	(County) Allegany	(State) MD		
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME		ADDRESS CUMBERLAND, MD	25a. REC'D. BY REGISTRAR DEC 27 1979	25b. REGISTRAR'S SIGNATURE J. J. Scarpelli				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

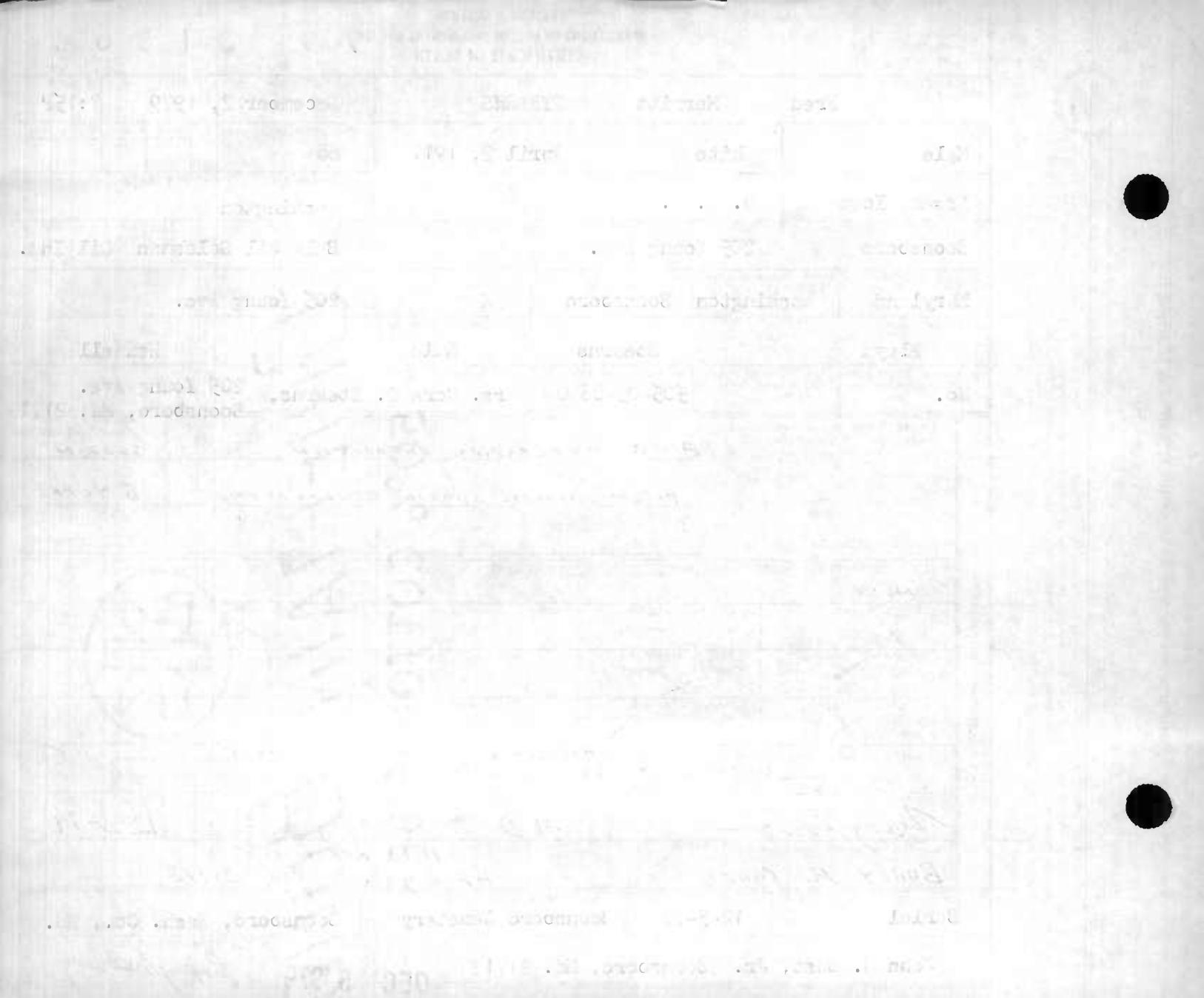
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/cremation permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Fred Merritt STEARNS						December 2, 1979						7:15P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1911		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
						68			MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Essex, Iowa		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BULK OIL Salesman			12b. KIND OF BUSINESS OR INDUSTRY Oil Ind. MD.	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 205 Young Ave.		12a. STREET ADDRESS 205 Young Ave.			12b. STREET ADDRESS 205 Young Ave.						
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 205 Young Ave.					
14. FATHER'S NAME FIRST Floyd		MIDDLE	LAST Stearns	15. MOTHER'S MAIDEN NAME FIRST Lulu		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 505-05-8630A		17. INFORMANT Mrs. Nora T. Stearns, 205 Young Ave. Boonsboro, Md. 21713			
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ACUTE MYOCARDIAL INFARCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) ANTERIOSCLEROTIC CARDIO-VASCULAR DISEASE										6 YEARS	
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE													
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <input checked="" type="checkbox"/> CITY OR TOWN <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE <input type="checkbox"/>									
22a. I certify that (this hospital) attended the deceased from OCTOBER 6, 1979, to PRESENT, 19, that (he/she) lost soul the deceased alive on NOVEMBER 19, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.													
22b. SIGNATURE Barry M. Cohen		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 12-3-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry M. Cohen		22e. ADDRESS 1198 KENLY AVE HAGERSTOWN, MD, 21740											
23a. BURIAL, CREMATION, REMOVAL (SELECT ONE) Burial		23b. DATE 12-5-79		23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery		23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.		25a. DATE REC'D. BY REGISTRAR DEC 5 1979		25b. REGISTRAR'S SIGNATURE Barry M. Cohen			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.		ADDRESS Boonsboro, Md. 21713											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 3 1 8 6 5			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		December 14, 1979		12:00P M		
Merrill			Brannan				STEEDMAN						
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				
						June 7, 1909			70				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Boonsboro			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeder Memorial Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman- Upholster Plant				
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Hebron			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST Alex			MIDDLE			LAST Steedman			15. MOTHER'S MAIDEN NAME FIRST Cecei				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 229-03-6641			17. INFORMANT Mrs. Virginia Bachman, Taneytown, Md. 21787			16c. ADDRESS 4506 Baptist Rd.				
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4151 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <input checked="" type="checkbox"/> DUE TO, OR AS A CONSEQUENCE OF Respiratory Failure. (c) <input type="checkbox"/> DUE TO, OR AS A CONSEQUENCE OF Pulmonary infarct? generally a heart attack. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/2/76, 1976, to 12/14/76, 1976, that (I) (we) last saw the deceased alive on 12/13/76, 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Bast, Jr.			22e. ADDRESS 11 Sheridan Dr., Williamsport, Md.										
23a. BURIAL, CREMATION, REMOVAL SPECIES Cremation			23b. DATE 12-17-79			23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory			23d. LOCATION CITY OR TOWN Smithsburg, Wash. Co., Md.		COUNTY STATE		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.			ADDRESS Boonsboro, Md. 21713			25a. DATE REC'D. BY REGISTRAR DEC 18 1979			25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
7 9 3 1 8 6 6											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Frank Curtiss Stouffer									Dec. 26, 1979			10 A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		Aug. 14, 1890			89						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. Co., Md.		USA								Washington			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Clearview Nursing Home		blacksmith			cement						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Washington		Hagerstown						304 Nottingham Road			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. ADDRESS						
Benjamin F. Stouffer				Mary - - Allen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no				Hazel L. Stouffer see # 13			6 hrs						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)													
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost } DUE TO, OR AS A CONSEQUENCE OF (b) Generalised arteriosclerosis } DUE TO, OR AS A CONSEQUENCE OF (c)													
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus. Bilateral leg amputee													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 57 30 19 74 to 12 16 19 78, that (I) (we) lost saw the deceased alive on 11/6 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.													
22b. SIGNATURE Robert V. Campbell MD		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 12/28/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert V. Campbell		22e. ADDRESS Hagerstown MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-79		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN Cemetery Cedar Lawn Mem. Pk. Hagerstown, Maryland			23d. LOCATION CITY OR TOWN Hagerstown, Maryland			23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		24a. ADDRESS 305 N. Potomac St. Hagerstown, Md.			24b. DATE REC'D. BY REGISTRAR JAN 3 1980			24c. REGISTRAR'S SIGNATURE Perry M. M.					

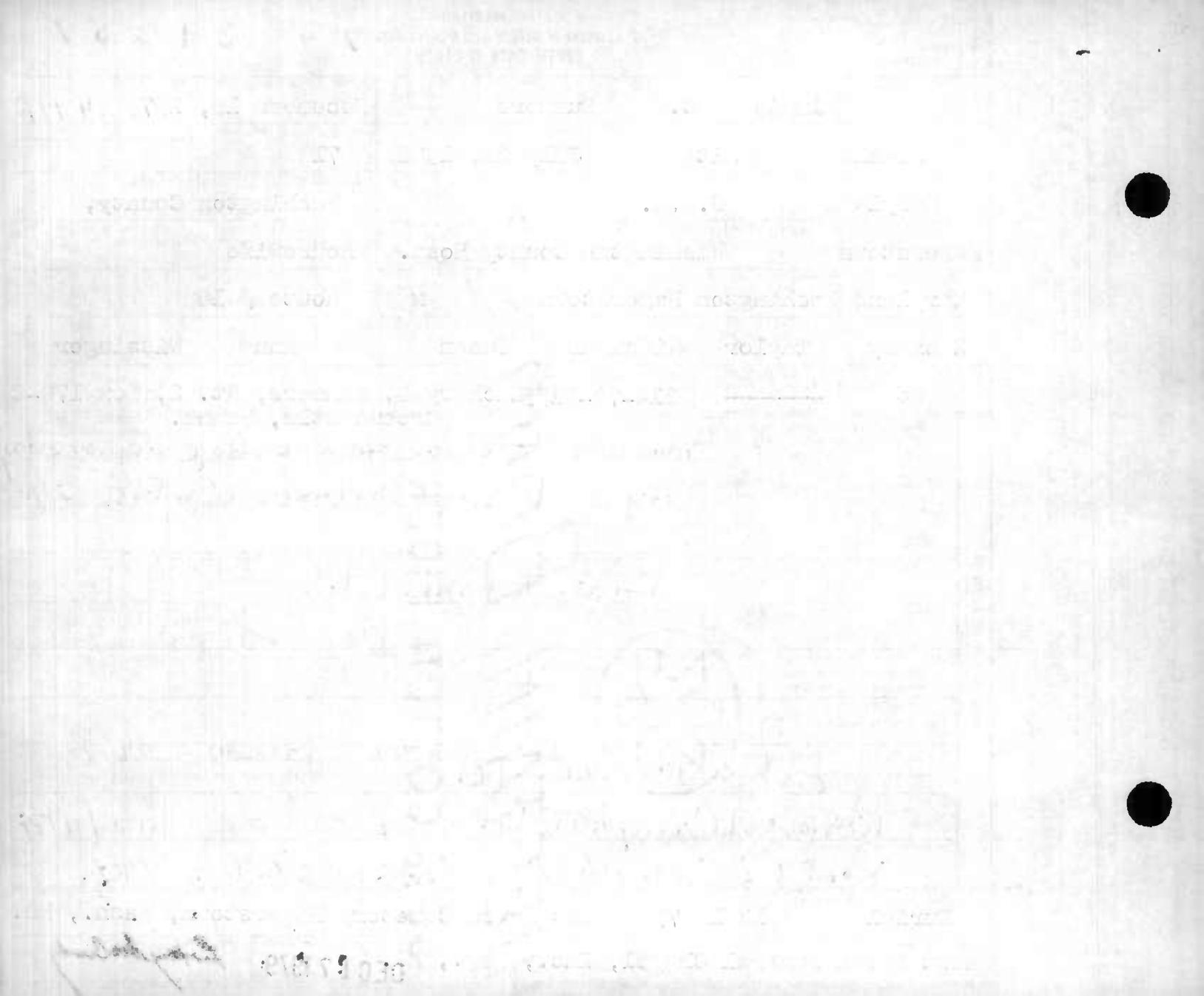
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed and attached.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
7 9 3 1 8 6 7											REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Winnie C. Summers									December 10, 1979					4 14 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		July 21, 1908				71		MONTHS	YEARS	MONTHS	HOURS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH						
Maryland		U.S.A.						Washington County,		Hagerstown						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Washington County Hosp.												Housewife		MD		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland Washington Hagerstown														Route # 10		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Zachary Taylor Ridenour			Susan Ann Wissinger													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
			214-74-2135			Zachary L. Summers, Rt. 2, Box 170-C			Greencastle, Penna.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4029 massive Cerebral Hemorrhage approx 2 day																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
b) Hypertensive Cardiovascular Dis. 2 yr																
DUE TO, OR AS A CONSEQUENCE OF (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 2 19 79 to Dec 10 19 79, the (I) (we) last saw the deceased alive on Dec 10 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																
22b. SIGNATURE Robert V. Campbell MD						DEGREE			22c. DATE SIGNED 12/11/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert V. Campbell						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/13/79			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY, STATE, COUNTY Hagerstown, Wash., Md.			23e. DATE REC'D. BY REGISTRAR DEC 17 1979			23f. REGISTRAR'S SIGNATURE Larry Bradley	
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hagerstown, Md.																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	6	8
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
LOTTIE M.					TAIT	12-31-19						4:53						
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS DAYS						
FEMALE			WHITE			9-19-1884			95			IF UNDER 24 HRS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH								
PENN.			USA									WASHINGTON CO. MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
HAGERSTOWN			COLTON VILLA NH			HOUSEWIFE			Home									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
MD.			WASH.			CLEAR SPR.						RFD-2						
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	16. SOCIAL SECURITY NO.			LAST						
CHARLES				WITMER	LILIE				183-07-8511			SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No						GEORGE TAIT.			CLEAR SPR. MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) 4392												yrs						
DUE TO, OR AS A CONSEQUENCE OF (b)																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)																		
DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN									
									COUNTY									
									STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1976</u> , to <u>12-31-1977</u> , that (I) (we) last saw the deceased alive on <u>12-24-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 1-1-80						
22b. SIGNATURE Vasant Datta						DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, M.D.			22e. ADDRESS 1600 OAKHILL AVE., HAGERSSTOWN, MD 21740															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 4, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Methodist			23d. LOCATION CITY OR TOWN Williamsport									
									COUNTY									
									STATE Pa.									
24. FUNERAL DIRECTOR NAME Donald E. Thompson Thompson Funeral Home			ADDRESS Clearspring Md.			25a. DATE REC'D. BY REGISTRAR JAN 3 1980			25b. REGISTRAR'S SIGNATURE Patty McLean									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

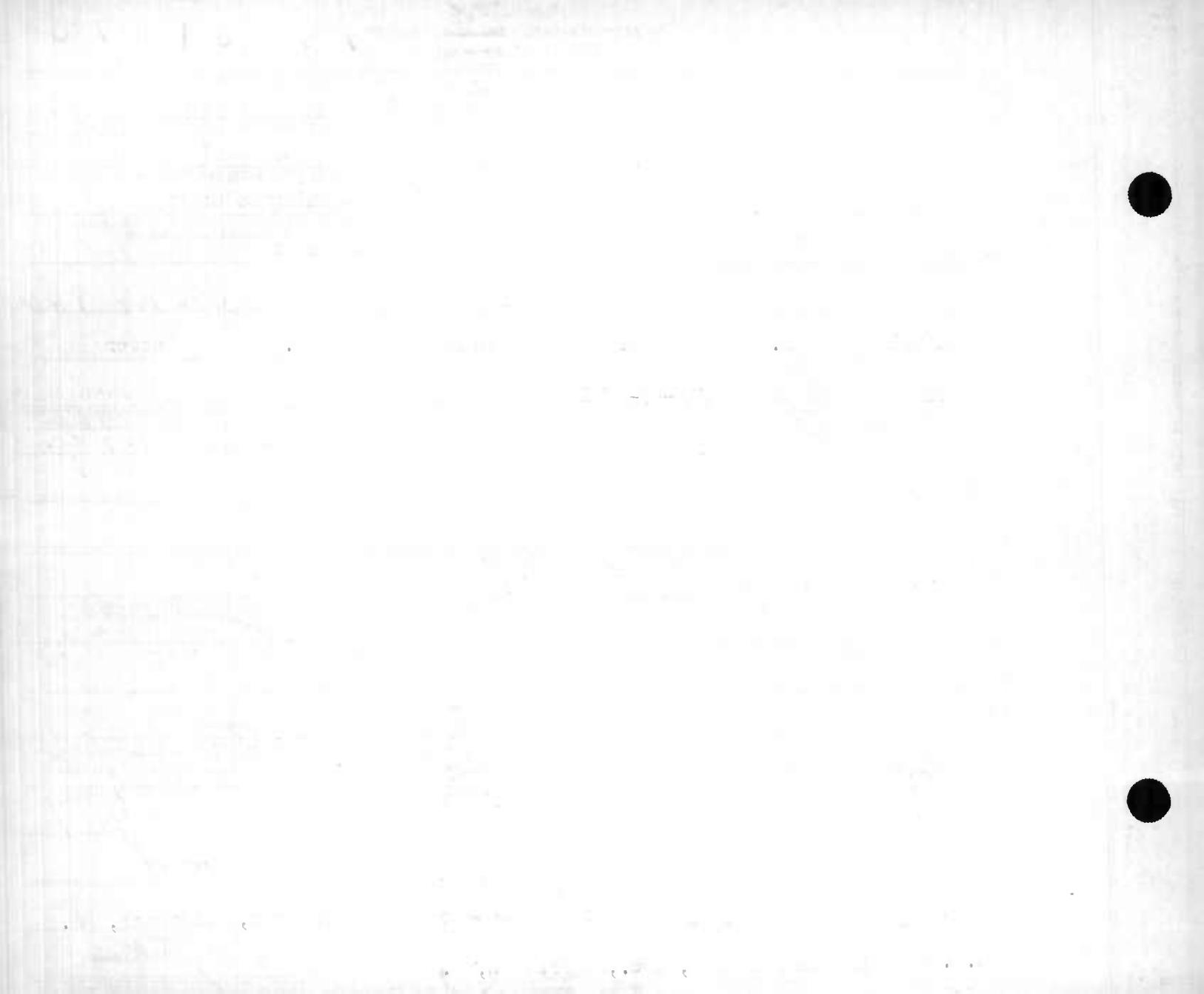
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH	DAY	YEAR	2b. HOUR
NEVILLE EDNA TAUVENNER												DECEMBER	6	1979	7:00 P.M.
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE			WHITE			MONTH DAY YEAR			89.			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
W.VA.			USA						WASHINGTON						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
DOWNSVILLE			CLEARVIEW NURSING HOME			CLERK			STATIONERY						
13a. STATE 13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
W.V.			BERKELEY MARTINSBURG			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			614 S. QUEEN STR.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
WILLIAM R.			LEWIS			MARY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO.			232-54-3510			JANE L. TAUVENNER			614 S. QUEEN STR.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4340 Cerebral anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												min.			
(b) Cerebral thrombosis												min.			
(c) Atherosclerosis												Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/4/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			22b. SIGNATURE J.D. Wilson, M.D.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED 12/7/79									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL BUREAU			23d. LOCATION CITY OR TOWN COUNTY STATE		23e. WASHINGTON COUNTY MD.				
CREMATION			DEC 7. 1979			SMITHSBURG CEMETERY			WASHINGT		SMITHSBURG				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
BOGEISCHART SONS INC MARTINSBURG W.V.			815 W. KING STR.			DEC 13 1979									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 7 0		
											REG. NO.			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Samuel Keefer Thomas						12 14 79			5 50 AM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			Caucasian			03 04 03			76			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Wash Co			USA						Washington County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co. Hospital						Salesman					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Md			Wash			Hagerstown						159 W. Wash St. Apt 101 Hagerstown		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Samuel F. Thomas			Laura V. Keefer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes WW II			219-05-9781			France Thomas			159 W. Wash St. Apt 101 Hagerstown					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Advanced liver disease, cancer													1-2 years	
5739 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Underlying: ABCD														
18. MEDICAL CERTIFICATION			19. DATE OF OPERATION			20. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY?			22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (i) this hospital attended the deceased from 3/28/79 to 8/28/79, that (ii) (we) last saw the deceased alive on 3/28/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) did not view the body after death.														
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED					
Richard J. Binford, MD									14 Oct 79					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS											
Richard J. Binford			Hagerstown, Md.											
22h. BURIAL, CREMATION, REMOVAL (SPECIFY)			22i. DATE			22j. NAME OF CEMETERY OR CREMATORIUM			22k. LOCATION CITY OR TOWN			COUNTY STATE		
Burial			12-17-79			Rose Hill Cemetery			Hagerstown, Washington, Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
A. K. Coffman Funeral Home, Inc., Hagerstown, Md.						DEC 19 1979			John J. Brady					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7	9	3	1	8	7	1			
												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Benjamin									Thompson			12			26	79		25			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						IF UNDER 1 YEAR		IF UNDER 24 HRS				
male			Caucasian			MONTH DAY YEAR			5 21 02			77			YRS		MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Williamsport, Md.			USA									Washington County, Md.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown			Avalon Manor			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			watchman			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY						
Maryland			Washington			Williamsport			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			22 E. Potomac St.			Retail						
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME									
Leo Duhamel			Thompson									Catherine Agnes Collins									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
WW 2			29075297						Coronary thrombosis						sudden						
410-						DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/11/75, 1979, to 12/26, 1979, that (I) (we) last saw the deceased alive on 12/12, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Duhamel												DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO												22e. ADDRESS 127 KING ST HAGERSTOWN MD									
23a. BURIAL, CREMATION, REMOVAL 19b. (IF Y)			23b. DATE 12-22-79			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE						
Baptist						Rose Hill Cemetery 305 N. Potomac St.			Hagerstown			Md.									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR 1AN 3 1980			25b. REGISTRAR'S SIGNATURE Peter J. Schenck												
Gerald N. Minnick			Hagerstown, Md.																		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 1 2	REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
HUEHY			JAMES			TRAIL						12 24 1979						12:43 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
Male			White			MONTH 6 DAY 4 YEAR 1904			75 YRS.			MONTHS			DAYS			HOURS MIN					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
W. VA.			United States			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington			Hagerstown			Washington County Hospital			Laborer			PENN DOT		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
PA.			Fulton			Warfordsburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST								
James			Edmond			Trail			Julia			Catherine			Bishop								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
No			205-09-0087			Thelma E. Trail Warfordsburg, PA			12 hrs														
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <u>SEVERE PULMONARY AND RENAL CONGESTION</u>																							
4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															12 hrs								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC FAILURE</u>															12 hrs								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>RUPTURED ABDOMINAL AORTIC ANEURYSM INTO INFERIOR VENA CAVA</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
12/24/79			RUPTURED ABDOMINAL AORTIC ANEURYSM			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22a. DATE SIGNED														
			P.M. 19						1/1/80														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/24 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			12/24 19 79			12/24 19 79																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED														
John R. Marsh			M.D.																				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE		
John R. Marsh, M.D.			239 N. POTOMAC STREET HAGERSTOWN, MD. 21740			Burial			12/28/79			Mays Chapel Chris. Warfordsburg			Fulton			PA.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Richard J. Lowe			Hancock MD.			JAN 16 1980																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	3	1	8	7	3
										REG. NO.						
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Ida Adyline TRUMPAVER						December 31 1979			8:10P M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		10 / 19 / 1890			89 YRS.			MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
MD.		United States					Washington									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown		Washington County Hospital			homemaker											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Wash.		Big Pool												
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Harris Wx xxxxxExxxxxxxxxxx Younker		Elizabeth Fink														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS									
NO		219-20-0762			Harris L. Trumpower		Big Pool, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										Pneumonia						
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic (or) Arteriosclerotic Disease																
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this) hospital attended the deceased from 12-19 19 79 to 12-31 19 79, that (I) (we) last saw the deceased alive on 12-31 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 1-2-80						
22b. SIGNATURE Eric M. Wagshal, M. D.										DEGREE MD						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
Eric M. Wagshal, M. D.										22e. ADDRESS 1825 Howell Rd., Hagerstown, Md. 21740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 1/3/80		23c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery			23d. LOCATION Clear Spring		23e. COUNTY WASH.		23f. STATE MD.					
24. FUNERAL DIRECTOR NAME Richard J. Lyons		ADDRESS Hancock MD		25a. DATE REC'D. BY REGISTRAR JAN 9 1980			25b. REGISTRAR'S SIGNATURE John J. Murphy									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

31874

REG. NO.

1. FOR STATE REGISTRAR			2. DATE KNOWN OF ESTI- MATED DEATH										3. HOUR MONTH DAY YEAR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<i>Amos F. Wetzel Sr</i>		4. DATE PRONOUNCED DEAD		5. HOUR MONTH DAY YEAR			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9. DATE PRONOUNCED DEAD		10. HOUR MONTH DAY YEAR	
M			C			Sept. 10, 1904			75 yrs.							Dec 14 1979		11:00 PM	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			12. CITIZEN OF WHAT COUNTRY?			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			14. CITY OR TOWN OF DEATH			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		16. KIND OF BUSINESS OR INDUSTRY					
Penns.			U.S.A.			Washington County Hosp.			Hagerstown			Labor Mailing		Paving					
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. STATE			19. COUNTY			20. CITY OR TOWN			21. ADDRESS		22. ADDRESS					
			Md.			Washington			Cascade			Box 261 Rouzerville, Penna.		17250					
23. FATHER'S NAME FIRST			24. MOTHER'S MAIDEN NAME FIRST			25. MIDDLE			26. LAST			27. ADDRESS		28. ADDRESS					
Harvey			Mary									Box 261 17250		Hardman					
29. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			30. SOCIAL SECURITY NO.			31. INFORMANT			32. ADDRESS			33. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
no			162-02-7385			Mrs. Mary F. Wetzel			Rouzerville, Pa.			450 minutes							
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1 DEATH WAS CAUSED BY:</p> <p>410 - IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> 410</p> <p>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</p> <p>(b) <i>coronary arteriosclerosis</i> 410 yrs</p> <p>(c)</p>																			
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).</p>																			
34. MEDICAL CERTIFICATION			35. DATE OF OPERATION			36. CONDITION FOR WHICH OPERATION WAS PERFORMED?			37. AUTOPSY?										
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
38. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			39. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B OR PART 2)													
41. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			42. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			43. LOCATION STREET			44. CITY OR TOWN			45. COUNTY							
												46. STATE							
<p>47. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>.</p>																			
48. ACTUAL SIGNATURE			49. TITLE (SPECIFY) M.D.			50. MEDICAL EXAMINER			51. DATE SIGNED										
			<i>Harold Tritch</i>									12/14/79							
52. EXAMINER'S NAME (TYPE OR PRINT)			53. ADDRESS			54. ADDRESS			55. ADDRESS			56. ADDRESS							
57. BURIAL, CREMATION, REMOVAL (SPECIFY)			58. DATE			59. NAME OF CEMETERY OR CREMATORIUM			60. LOCATION CITY OR TOWN			61. COUNTY							
Burial			12/18/1979			Harbaugh Church Cem.			Rouzerville Franklin			Penns.							
62. FUNERAL DIRECTOR NAME			63. ADDRESS			64. DATE REC'D. BY REGISTRAR			65. REGISTRAR'S SIGNATURE										
<i>Harold Tritch</i>			Waynesboro, Penna.			DEC 20 1979													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 8 7 5	REG. NO.						
1 - STATE REGISTRAR			I DECEASED NAME [TYPE OR PRINT]			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			William Austin Wiseman						December 20, 1979			5:43 A M					
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR August 27, 1889			6. AGE [IN YEARS LAST BIRTHDAY] 90 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION [IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS] Avalon Manor Nursing Home			12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE] carman			12b. KIND OF BUSINESS OR INDUSTRY railroad								
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 620 Summit Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST William Baxter Wiseman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Sensenbaugh			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO OR UNKNOWN] No			16b. SOCIAL SECURITY NO 705-10-8626			17. INFORMANT Mrs. Dorothy Vaverchak, Hagerstown, Md.			ADDRESS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			pneumonia			496 -			DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive pulmonary disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									DUE TO, OR AS A CONSEQUENCE OF (c)						years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from December 4, 1979, to December 20, 1979, that (1) (I) last saw the deceased alive on December 17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (I) (We) did not view the body after death.																	
22b. SIGNATURE Howard N. Weeks, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED December 21, 1979								
22d. PHYSICIAN'S NAME [TYPE OR PRINT] Howard N. Weeks, M.D.			22e. ADDRESS Hagerstown, Maryland 21740														
23a. BURIAL, CREMATION, REMOVAL [SPECIFY]			23b. DATE Dec. 22, 1979			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland								
24. FUNERAL DIRECTOR Minnich Funeral Home NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR DEC 24 1979			25b. REGISTRAR'S SIGNATURE Mary McCreary								

BP

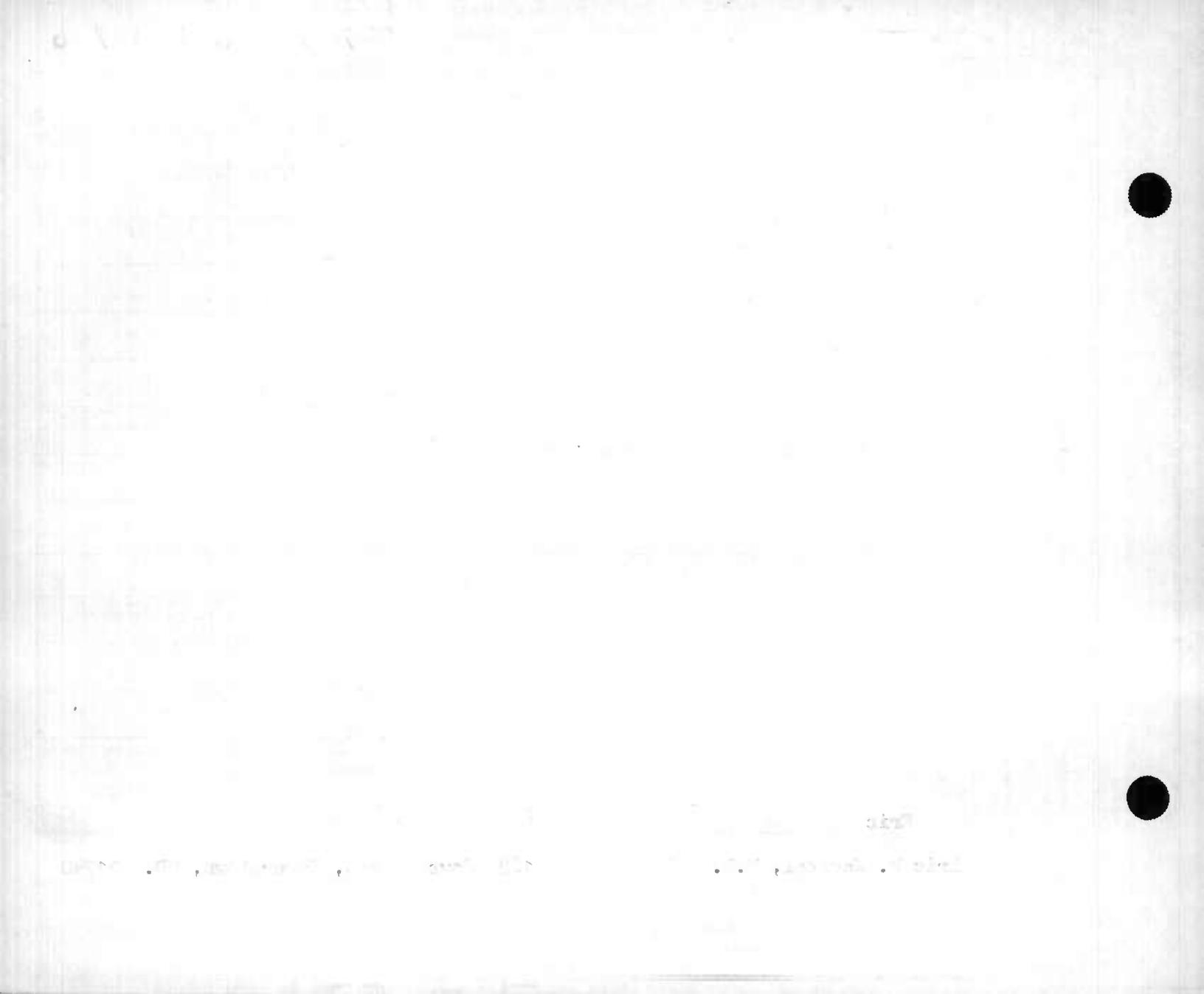
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(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7931876					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
James Bradley WITHERSPOON Sr.						December 25, 1979									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		white		May 19, 1910			69			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Pennsylvania		USA					Washington								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington County Hospital								salesman			real estate		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1133 Hamilton Boulevard						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
S. Bradley Witherspoon			Jeanne Mamaux												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		217-12-1663		Charlotte Witherspoon, Hagerstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)															
DUE TO, OR AS A CONSEQUENCE OF (b) (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Eric M. Wagshal, M.D.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1825 Howell Road, Hagerstown, MD. 21740	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery			23d. LOCATION CITY OR TOWN Mercersburg, Pa.		COUNTY				STATE		
burial		Dec. 28, 1979													
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR ADDRESS						25b. REGISTRAR'S SIGNATURE							
Minnich Funeral Home		JAN 2 1980													
415 E. Wilson Blvd., Hagerstown, Md. 21740															



LO

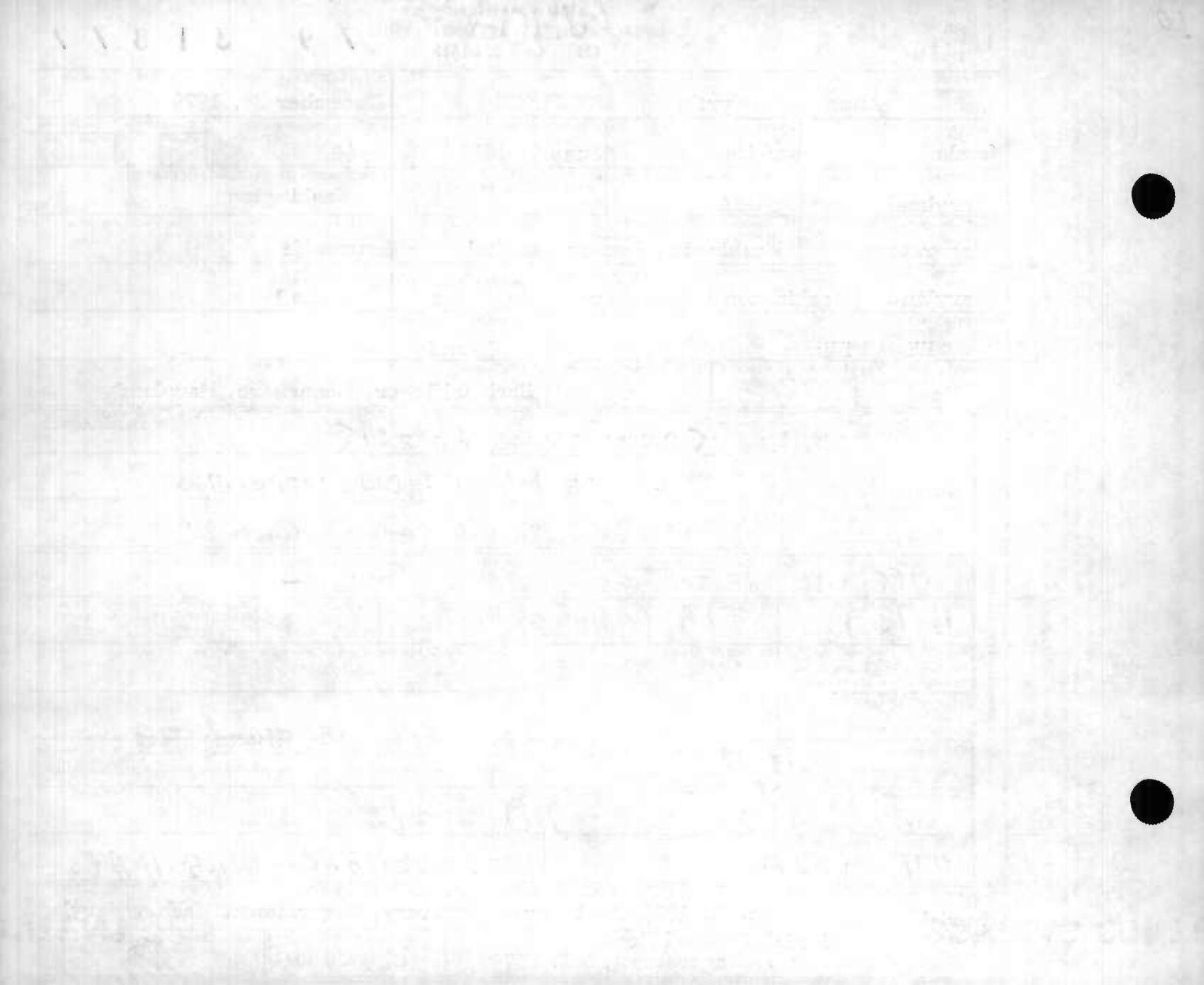
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 31877

REG. NO.

1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Anna Myrtle WOLFINGER						December 20, 1979					
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		white		June 7, 1919		60		YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		USA						Washington			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital				housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1			
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
William Williams			Annie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
No				Earl Wolfinger, Boonsboro, Maryland							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						CARIOGENIC SHOCK					
DUE TO, OR AS A CONSEQUENCE OF (b)						ACUTE MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF (c)						ATHEROSCLEROTIC CORONARY OCCLUSIONS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 12.18.79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED T.I.A.; CAROTID OBSTRUCTION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>October 1972</u> to <u>13. December 1979</u> , that (I) (we) last saw the deceased alive on <u>12.18.79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZIA			22e. ADDRESS 100 Long Meadow Drive Hagerstown, Wash., Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Dec. 22, 1979			23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		
24 FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR DEC 24 1979			25b. REGISTRAR'S SIGNATURE Marilyn McCreary					
DHMH-16 25M (VRA 15, 4) 1/79											



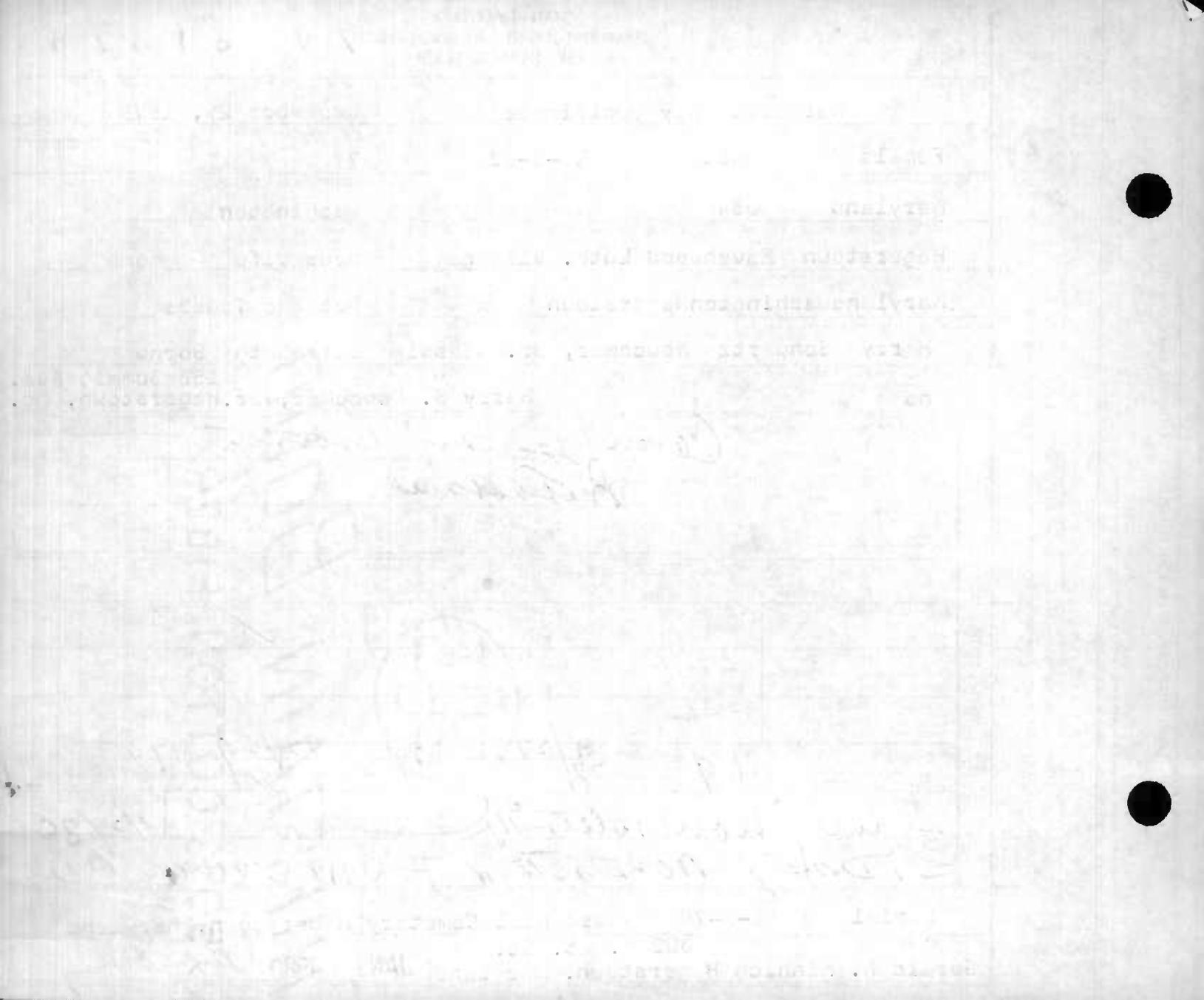
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	3	1	8	7	8	
										REG. NO. 7931878							
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Margaret May Wolfinger									December 29, 1979					M			
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 2002 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS DAYS		9. IF UNDER 24 HRS HOURS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Luth. Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Potomac Towers		14. FATHER'S NAME FIRST Harry MIDDLE Schwartz LAST Newcomer, Sr.		15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE Elizabeth LAST Borne				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Harry S. Newcomer, Jr.		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1536 DUE TO, OR AS A CONSEQUENCE OF b) <i>Cancer of ascending Colon c</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } b) <i>metastases.</i> c) <i></i>		19. ADDRESS 153 Summit Ave. Hagerstown, Md.		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 16a										21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION STREET		22d. CITY OR TOWN		22e. COUNTY		22f. STATE	
22g. I certify that (I) (this hospital) afforded the deceased from 9/27, 1979, to 12/29, 1979, that (I) (we) last saw the deceased alive on 12/19, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.																	
22h. SIGNATURE <i>Sidney Newcomer MD</i>		22i. DEGREE <i>Attending Physician</i>		22j. ATTENDING PHYSICIAN <input type="checkbox"/>		22k. MEDICAL DIRECTOR <input type="checkbox"/>		22l. STAFF PHYSICIAN <input type="checkbox"/>		22m. DATE SIGNED 11/1/80							
22n. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. Sidney Newcomer Funkhouser MD</i>		22o. ADDRESS <i>51 Dudley Newcomer Funkhouser MD</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-3-79		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Maryland		23e. COUNTY		23f. STATE							
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		25a. ADDRESS 305 N. Pt. St.		25b. DATE REC'D. BY REGISTRAR JAN 1 1 1980		25c. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 3. FOR FEE PAYMENT, FEE TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31879

1- STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR MONTH DAY YEAR						
		John			Edward			WRIGHT				Dec 4 1979		10 AM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR MONTH DAY YEAR					
M		W		May 8, 1906			73 yrs.		MONTHS		DAYS		HOURS		MIN.		Dec 4 1979		2:52 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		U.S.A.												WASHINGTON MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Washington County Hospital										Shepherd College		Maintenance						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS												
Maryland		Washington		Sharpsburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1 Sharpsburg, MD												
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST										
George				Wright		Lidia				Falls										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										17. INFORMANT		ADDRESS						
NO		215-26-9073										Julia Kline								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				
PART I DEATH WAS CAUSED BY:																				
IMMEDIATE CAUSE (a) (410) coronary occlusion																				
DUE TO, OR AS A CONSEQUENCE OF																				
410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																				
(b) _____																				
DUE TO, OR AS A CONSEQUENCE OF																				
(c) _____																				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden																				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?								
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion																				
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE		H. N. Weeks										TITLE (SPECIFY) M.D.		MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN														
Burial		Dec 7, 1979		Mountain View Cemetery		Sharpsburg		Washington DC												
24. FUNERAL DIRECTOR NAME		ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Osborne Funeral Home P.O. Box 348 Wmspt., MD												DEC 11 1979		R. H. Weeks						

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after being detached for use as the burial/transit permit. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 8 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
JOHN KENNETH WRIGHT						DEC	7	1979	1 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		CAU White		MONTH DAY YEAR May 12, 1928		51		MONTHS DAYS		HOURS MIN	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON Co.		10. CITY OR TOWN OF DEATH HAGENSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. CO HOSP	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.		13b. COUNTY FREDERICK		13c. CITY OR TOWN FREDERICK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7913 Runnymead Drive	
14. FATHER'S NAME FIRST Ernest		MIDDLE		LAST Wright		15. MOTHER'S MAIDEN NAME FIRST Katherine		MIDDLE		LAST Elsröde	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. IF YES, GIVE WAR OR DATES Korean		16c. SOCIAL SECURITY NO 217-24-3440		17. INFORMANT Mrs. Jean Wright,		18. ADDRESS 7913 Runnymead Drive Frederick, Md. 21701		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MOS	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b1, and 1c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a) CARCINOMA OF LUNG WITH WIDESPREAD METASTASES											
1629 Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the physician) attended the deceased from Nov 27 1979 to DEC 7 1979, that (I) (we) last saw the deceased alive on DEC 6 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Joel L Rosenthal		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 12-7-79					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL L Rosenthal		22g. ADDRESS 1198 KENLY AVE. HAGENSTOWN, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 10, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick		CITY OR TOWN Frederick		COUNTY STATE	
24. FUNERAL DIRECTOR Smith, Fadeley, Keeney, Bassford Funeral Home 106 East Church Street, Frederick, Md. 21701						25a. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE Loyalty McBrady			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 1 8 8 1	REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	40			
			Glenn Frederick Yeakle						12-2-79						4 AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			White			Aug. 26, 1921			58			MONTHS	YEARS	MONTHS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland			U.S.A.						Washington										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington County			13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Williamsport			13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD-2			Steel				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) YES WW-2			16b. SOCIAL SECURITY NO. 215-18-1459			17. INFORMANT Mrs. Christine Yeakle			ADDRESS Williamsport				
John Yeakle			Julia Clopper																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Myocardial Infarct			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes							
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) Coronary Atherosclerosis						10 years							
						(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pecten Ulcer																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED 12-2-79				
22b. SIGNATURE W.W. Lee			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 4, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Blairs Valley			23d. LOCATION CITY OR TOWN Clearspring Wash. Md.			COUNTY STATE							
24. FUNERAL DIRECTOR NAME: Donald E. Thompson Thompson Funeral Home			25a. DATE REC'D. BY REGISTRAR DEC 6 1979			25b. REGISTRAR'S SIGNATURE John J. Brady													

1960-1961
Montgomery
Montgomery, N.Y.

1961-1962

8PM

8-1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical committee must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1 - FOR STATE REGISTRAR				REG. NO. 7 9 3 1 8 8 2											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Mary		A.				Yeingst		December		31	79	12:15 ^m	P		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Female		White		MONTH DAY YEAR 9- 21 - 86		93		MONTHS DAYS		HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD							
Pennsylvania		U.S.A.				Washington									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown		Colton Villa Nursing Center		Housewife											
13a. STATE MD		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 329 West Side Avenue							
14. FATHER'S NAME Willard		15. MOTHER'S MAIDEN NAME Annebelle													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 214-09-0152		17. INFORMANT Ray W. Sweger		ADDRESS Harrisburg, Penna.									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) _____ } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yr			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12.14.</u> 19 <u>79</u> , to <u>12.31.</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12.24.</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 1-1-1980			
22b. SIGNATURE Vasant Datta		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, M.D.		22e. ADDRESS 1600 OAK HILL AVE, HAGERSTOWN, MD 21740													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-3-80		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cem.		23d. LOCATION CITY OR TOWN Hagerstown Wash.		COUNTY		STATE MD					
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel		ADDRESS 1601 Penna. Ave. Hagerstown, MD		25a. DATE REC'D. BY REGISTRAR JAN '79		25b. REGISTRAR'S SIGNATURE Vasant Datta									

